



An investigation of the relationship of loneliness of the hospitalized patient to continuity of contact by nursing personnel
by Marlene Ellen Tracy

A thesis submitted to the Graduate Faculty in partial fulfillment of the requirements for the degree of
MASTER OF NURSING
Montana State University
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Abstract:

The purpose of this study was to determine implications for nursing about a specific problem area in nurse-patient relationships in the hospital. The specific problem area dealt with in this study was the experience of loneliness of the hospitalized patient. The relationship between continuity of contact by nurses and feelings of loneliness of the hospitalized patient was investigated.

To study this problem it was necessary to: (1) evaluate nursing staffing policies to determine if hospitals provided for continuity of contact between nurses and patients; (2) determine if patients experience feelings of loneliness while hospitalized; (3) determine if patients are able to identify continuity of contact by nurses; (4) determine if patients are able to, identify and express their feelings of loneliness while hospitalized; and (5) identify those instances in which patient loneliness occurs in the presence of continuity of hospital staffing.

A Patient Opinionnaire, developed for the study in a manner similar to the Q-sort technique, was administered to sixty-four medical-surgical patients in five general hospitals in Montana. The sample of patients was chosen by means of a modified, selected sampling procedure. An interview with patients, on their feelings of loneliness while hospitalized, followed the opinionnaire.

A questionnaire was completed by head nurses on seventeen hospital wards where patients were tested in the five hospitals. The purpose of the nursing questionnaire was to determine types of nursing in operation in the five hospitals, the method of staffing ---- regular nursing staff on the wards or frequent use of float nurses for staffing purposes ---, and to determine if continuity of nursing contact was provided for patients.

The Patient Opinonnaires were analyzed to determine the amount of discrepancy between the patients' ideal opinion of hospitalization and their actual hospital experience .

Results of this study indicate that patients do experience feelings of loneliness while hospitalized and that there was a relationship between continuity of contact by nurses and the patients' experience of loneliness. The crucial aspect of the relationship between continuity of contact and loneliness was the quality of contact between nurses and patients. Verbatim responses of patients to questions of loneliness, included in the study, implied the need for nurses to resensitize themselves to patients' emotional needs and become more actively involved with hospital patients.

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AN INVESTIGATION OF THE RELATIONSHIP OF LONELINESS
OF THE HOSPITALIZED PATIENT TO CONTINUITY
OF CONTACT BY NURSING PERSONNEL

by

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A thesis submitted to the Graduate Faculty in partial
fulfillment of the requirements for the degree

of

MASTER OF NURSING

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June, 1974

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In cherished and loving memory to

Mother

and

Daddy,

and my friends,

Eileen Sahinen

and

Coral Collins

And there are those who have little
and give it all.

These are the believers in life and the
bounty of life, and their coffer is never empty.

There are those who give with joy,
and that joy is their reward.

And there are those who give with pain,
and that pain is their baptism.

And there are those who give and know not
pain in giving, nor do they seek joy, nor give
with mindfulness of virtue;

They give as in yonder valley the myrtle
breathes its fragrance into space.

Through the hands of such as these God
speaks, and from behind their eyes He smiles
upon the earth.

Kahil Gibran, The Prophet

ACKNOWLEDGEMENTS

The author wishes to express her sincere thanks and appreciation to the following persons:

The members of my Graduate Committee, Miss Virginia Felton, Chairman, Mrs. Margaret Vojnovich, Mrs. Milly Gutkoski, Dr. Richard Horswill, for their interest, assistance and guidance. Most of all, sincere appreciation is expressed for their enduring patience during the formulation and completion of this thesis.

To all the members of my family for their ever constant love and belief in me, without which nothing would be important or possible.

The Directors of Nurses, nursing personnel, and patients from the five hospitals whose cooperation made this study possible.

To my friends and classmates, and to a special friend, Dr. George Hossack, for motivating the author and the thesis towards "becoming".

A special acknowledgement and thank-you to:

Jim Cody, Montana State University student, for his assistance in collection of data.

Dr. Al Suvak for his guidance and most welcome assistance in formulation of the opinionnaire and analysis of data.

Lanette Moehling for her constant support and her help in bringing the paper to completion.

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ABSTRACT

The purpose of this study was to determine implications for nursing about a specific problem area in nurse-patient relationships in the hospital. The specific problem area dealt with in this study was the experience of loneliness of the hospitalized patient. The relationship between continuity of contact by nurses and feelings of loneliness of the hospitalized patient was investigated.

To study this problem it was necessary to: (1) evaluate nursing staffing policies to determine if hospitals provided for continuity of contact between nurses and patients; (2) determine if patients experience feelings of loneliness while hospitalized; (3) determine if patients are able to identify continuity of contact by nurses; (4) determine if patients are able to identify and express their feelings of loneliness while hospitalized; and (5) identify those instances in which patient loneliness occurs in the presence of continuity of hospital staffing.

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CHAPTER I

INTRODUCTION

The hospitalized patient of today receives nursing care from several different members of the nursing staff each day. Because of this fragmentation of nursing care services, nurses frequently have less than adequate knowledge about their patients. However, the traditional characterization of professional practice is the one-to-one client-professional relationship.¹

The investigator of this study believes the nurse-patient relationship, then, as a professional relationship should be characterized as a one-to-one helping relationship. Carl Rogers defines a helping relationship as one in which "at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning, improved coping with the life of the other".²

Rogers further expresses that being helpful to another requires an ability to understand meanings and feelings -- essentially a desire to understand. A sensitivity to

¹Marie Manthey, et. al, "Primary Nursing", Nursing Forum, Vol. IX, No. 1, (1970), p. 65.

²Carl Rogers, "The Characteristics of a Helping Relationship", Personnel and Guidance Journal, Vol. XXVII, (September, 1958), p. 6.

attitudes, a warm interest without emotional over-involvement and the way in which attitudes are perceived by the person being helped are the crucial aspects of a helping relationship.³

The researcher believes that in order for any one-to-one relationship, and in particular a nurse-patient helping relationship, to exist, there must also be a consistency or continuity of contact between the individuals involved in the relationship. Nursing care services become fragmented and inconsistent for many reasons, among which are the alternating of nursing personnel from team to team on the same ward, the rotation of nursing personnel from ward to ward, because, in many instances, hospitals are staffed from a "float pool", or even because of impersonalization on the part of nurses. The hospital's particular approach to nursing care can also influence fragmentation. The functional approach to nursing employs a task approach to nursing care services in which a separate nurse is utilized for each nursing care function, or task. The functional approach to nursing care, then, employs a nurse who is in charge, a nurse who distributes medications

³Ibid.

and a nurse who performs the "treatments" or nursing care procedures for an entire ward or hospital unit. The medicine nurse and treatment nurse may be the same person. The team approach to nursing care divides a hospital ward into "teams". Each team employs a team leader who is responsible for the nursing care of the patients assigned to that team. The team leader may also be responsible for medications and nursing care procedures, or another nurse, perhaps a Licensed Practical Nurse, may perform the duties of distributing medications and carrying out nursing care procedures.

In some hospitals a combination of both functional and team nursing is employed; for example, team nursing may be in operation during the day time and functional nursing in operation during the evening hours. Both approaches are then complemented by auxiliary personnel of Licensed Practical Nurses, nursing assistants and aides.

In addition, there are also inhalation therapists tending machines, laboratory personnel, X-ray technicians, dietary personnel, and many others who come and go in a patient's room every day.

Patient care, and even the patient himself suffers because of this lack of continuity of contact by nursing personnel and others. The hospitalized patient, removed

from his familiar environment, separated from friends and family can become bewildered and lost in the flow of traffic which enters and leaves his hospital room each day. Unless he has some continuity of contact, someone to whom he can relate and express himself, the patient will experience alienation and loneliness.

Hospital workers must often wonder how patients can possibly be lonely when one person after another is running in and out of their rooms. Patients testify, however, that the almost endless number of persons and their continued 'running' do little to allay loneliness and often accentuate it.⁴

Many of the complaints of the "demanding patient" which perplex nurses can be a result of the pain of loneliness.

Few people realize that loneliness can bring sheer physical pain. Few realize how terribly dependent they are on the closeness of another person The aching throat, the recurring headaches, the churning early morning stomach, the painful back, the iron band around the ribs -- these are part of loneliness⁵

⁴Esther Lucile Brown, Newer Dimensions of Patient Care, Part I, (New York: Russell Sage Foundations, 1961), p. 22.

⁵Angela Reed, The Woman on the Verge of Divorce, (London: Thomas Nelson and Sons, Limited, 1970), p. 51

Loneliness and it's accompanying feelings of alienation and intense anxiety have no therapeutic effects. This study is concerned with the therapeutic effects of the interpersonal relationships of the patient and the nurse, and in particular the effects of a lack of continuity of contact by nursing personnel and its relationship to patient loneliness.

STATEMENT OF THE PROBLEM

The problem of this study was to determine the relationship between continuity of contact by nursing personnel and feelings of loneliness and alienation in the hospitalized patient.

PURPOSES OF THE STUDY

The purposes of this study were: 1) To evaluate nursing staffing policies in five general hospitals to determine if these hospitals provide for continuity of contact between nurses and patients; 2) To determine if medical-surgical patients in five general hospitals experience feelings of loneliness while hospitalized; 3) To determine if patients are able to identify consistency and continuity of contact by nurses; 4) To determine if patients are able to identify and express their feelings about loneliness during

hospitalization; 5) To identify those instances in which patient loneliness occurs even in the presence of continuity of hospital staffing; and 6) To determine from these findings implications for nurses directed toward improved, quality nursing care services for the hospitalized patient.

BASIC ASSUMPTIONS

For purposes of this study, the investigator makes the following assumptions:

1. Continuity of contact between nurses and patients is an important factor in the hospitalized patient's well-being.
2. The period of hospitalization is a time of loneliness for patients.
3. Nursing care of a hospitalized patient encompasses the concern for all aspects of the patient as a unity -- the physical, psychological, emotional and social aspects of the total person.

LIMITATIONS

1. The study was limited to patients and nursing personnel from five general hospitals in Montana.
2. The study was further limited in that the five

hospitals were located in only three cities in Montana.

3. There was a limited sample size drawn from each hospital.

RESEARCH DESIGN

The study was based on a descriptive survey of a sample population of patients from five hospitals in Montana. The purpose of the descriptive approach was to portray characteristics of nurse-patient relationships and to determine the frequency with which loneliness occurs in the hospitalized patient and is associated with consistency or continuity of contact (or the lack) of by nurses.

A patient opinionnaire, patterned after the Q-sort technique, was the measuring instrument administered to patients in the study. The patient opinionnaire was devised to measure discrepancies in nurse-patient relationships and, in particular, patients' opinions of the ideal hospital situation and their actual experiences as a hospitalized patient. A detailed description and explanation of the patient opinionnaire will be included in Chapter III.

In addition to the patient opinionnaire, patients were asked to respond verbally to a question about their own feelings of loneliness while hospitalized. Verbatim respon-

ses of patients about loneliness were recorded on the patient data tabulation sheet.

The sample population for the study was a total of sixty-four patients from the five hospitals. Patients were selected in each of the five hospitals by a selected sampling method. Due to individual hospital differences, the sampling method was modified for each hospital. Five of the total sixty-four patients were the patients selected to complete the patient opinionnaire in a pilot testing of the instrument.

A brief questionnaire was devised by the investigator and administered to the head nurse or nurse in charge on hospital wards where patients completed the patient opinionnaire. Nurses were asked to stipulate the type of nursing care in operation on their ward, for example, a functional approach to nursing care or a team approach to nursing care. In addition, nurses answered questions about rotation of nursing staff and the use of float nurses on their ward. The study's definition of continuity of contact by nurses was stated on the questionnaire and nurses were asked to state whether or not their particular ward provided continuity or contact by nurses to patients.

The responses of the sixty-four patients on the

opinionnaire provide the basic data for the study. The results of patient responses on the opinionnaire were analyzed to determine the degree of discrepancy between ideal hospital situations and patients' actual hospital experiences.

HYPOTHESIS

There is no relationship between continuity of contact by nurses and loneliness experienced by the hospitalized patient.

DEFINITION OF TERMS

Nursing Personnel - for purposes of this study, nursing personnel will include only Registered Nurses. Nurses aides, orderlies and Licensed Practical Nurses will be referred to specifically by their titles.

Nurse - the "nurse" in this study will always refer to the Registered Nurse, the R. N.

Fragmentation - in this study refers to the break-down of nursing care of a patient when it is administered by a variety of hospital staff.

Isolation - the separation of a particular patient from other patients on the ward in a private room and the use of special nursing care procedures to pre-

vent the spread of communicable disease or infection to others.

Functional Nursing - this system of care involves a method of work organization and personnel assignment that is job centered or task oriented. Personnel are fitted into fixed slots; one person passes medications, another administers treatments and others give hygienic care, serve at the desk recording for staff, or serve as liason between patients, doctors, family members and others who have concern with the patients.⁶

Team Nursing - a group of people, led by a qualified nurse, provide for the health needs of an individual or a group of people through collaborative and cooperative effort. Through the team process of providing care, the team leader plans, participates in, coordinates, interprets, supervises, and evaluates the care that is given.⁷

⁶Laura Mae Douglass, Review of Team Nursing, (Saint Louis: The C. V. Mosby Company, 1973), p. 6.

⁷Ibid. p. 2.

Float Nurse - to "float", in hospital terminology, means that a nurse is assigned to a different ward or floor than the one where she normally is assigned. Floating occurs; due to fluctuations in hospital census -- where one ward may need more personnel because of more patients than another ward; because a regularly assigned nurse may need to be replaced due to illness, days off, or the like; because one ward may have patients requiring more personnel for nursing care than another ward; or because a ward may not have a regularly assigned staff of nurses and must be staffed by float nurses.

A nurse who does not have a regularly assigned ward, and who is assigned from day to day wherever needed in the hospital is called a "float nurse". A group of nurses who consistently float from ward to ward and are assigned by the nursing service office on a day to day basis, comprise a "float pool".

Continuity of Nursing Contact - nursing care given to a patient by the same nurse on two or more consecu-

tive days.⁸ The term "care" is taken to include the physical, psychological, emotional aspects of the patient, responsibility for the patient and/or patient care needs, nurse-patient interactions, and direct nursing care.

Loneliness -

In loneliness, some compelling essential aspect of life is suddenly challenged, threatened, altered, denied . . .⁹ It occurs in the presence of tragedy, illness and death; it is associated with a new truth that suddenly shatters old perceptions or ideas; it is connected with feeling different from other members of a group or feeling misunderstood and apart from others, with a sense of not belonging. It is frequently associated with broken relationships and separation experiences.¹⁰

Loneliness can also occur when a person "remains silent and withdrawn though surrounded by people . . ."¹¹ It must be noted that there are many, many kinds of loneliness and that loneliness can

⁸Elmina M. Price, Staffing For Patient Care, (New York: Springer Publishing Company, Inc., 1970), p. 133.

⁹Clark E. Moustakas, Loneliness and Love, (New Jersey: Prentice-Hall, Inc., 1972), p. 21.

¹⁰Ibid., p. 45.

¹¹Ibid., p. 50.

only be defined by each person for each experience, for experiences of loneliness are as unique as every individual.

SUMMARY OF CHAPTER I

AND

OVERVIEW OF THE REMAINDER OF THE STUDY

This study was concerned with the nurse-patient relationship and the amount and degree of interaction that occurs between the nurse and patients in selected hospitals in Montana. Continuity of contact between nurses and patients was examined to determine if a relationship exists between continuity of contact (or a lack of it) and loneliness in the hospitalized patient. A selected sample population of patients was tested in the study to determine if loneliness exists in the selected hospitals.

Many untoward effects on the patient and patient care occur because of fragmentation of nursing care. Loneliness of the hospitalized patient was the primary concern in this study as a result of fragmentation of nursing services. Although loneliness is an experience that everyone encounters from time to time in their lives, an understanding of the causes of loneliness in hospitalized patients and its relationship to care by nursing personnel is necessary

if quality nursing care is to be given.

The second chapter of the study presents a review of the related literature. The third chapter contains the study methodology, description of the opinionnaire, variables encountered in the study. The fourth chapter contains the analysis of data. The fifth chapter presents a summary of the study, conclusions, recommendations for further study, and implications of the study for nursing.

CHAPTER II

REVIEW OF LITERATURE

Out here they got a name for rain,
For wind and fire only.
But when you're lost, and all alone,
There ain't no word for lonely.¹²

One of the crucial aspects of patient care in any hospital is the network of interpersonal relationships between the patient, the nurse, the physician, and members of the patient's family.¹³ Patient care is effective if this closely united network allows for satisfaction of patient needs and hospital staff needs. If needs are not met, patient care suffers. This study was concerned with interpersonal relationships of the patient and the nurse, and meeting the patient's needs. One of the ways patient care suffers can be due to a lack of continuity of nurse-patient contact. The nurse-patient relationship can be termed a helping relationship, but only if there is continuity of contact and consistency of care between the persons involved in that relationship. Many untoward effects on the patient

¹²Alan Jay Lerner and Friederick Loewe, "They Call the Wind Maria," (New York: Chappell Company, Inc., Publishers, 1951).

¹³J. Frank Whiting, "Patients' Needs, Nurses' Needs and the Healing Process", American Journal of Nursing, Vol. 59, No. 5, (May, 1959), p. 662.

can result from inconsistent nursing care. One of these is that the patient experiences feelings of loneliness and alienation in the hospital. The frequency and variety of hospital personnel which enter the patient's environment can also add to the patient's experiencing increased alienation and in loneliness in the hospital setting.

Within the last twenty years a steady increase has occurred in the number of articles in the literature on the subject of loneliness. Poets and novelists have described loneliness and professionals such as Frieda Fromm-Reichmann, H. S. Sullivan, Clark Moustakas have shown interest in this subject.¹⁴ A sociology professor at Bates College in Maine, Dr. William Sadler, Jr., has conducted a series of workshops at Bates on the subject of "Loneliness in America". Dr. Sadler considers loneliness a subtle and dangerous social disease that has been evaded and misunderstood too long.¹⁵

In reviewing the literature on the subject of loneliness, the investigator found numerous articles describing

¹⁴Irene Mortenson Burnside, "Loneliness in Old Age", Mental Hygiene, Vol. 55, No. 3, (July, 1971), p. 391.

¹⁵Jack Aley, "To Be Human Is To Be Lonely", The Billings Gazette, (February 13, 1973).

and identifying loneliness; however, few actual research studies into the subject are available. The review of literature presented here will review some of the recent articles and books written on or including the topic of loneliness from 1953 to 1973.

Dr. Elisabeth Kübler-Ross worked with dying patients for two and a half years before writing the book On Death and Dying. Dr. Ross describes dying in today's world as "more gruesome in many ways, more lonely, mechanical, and dehumanized" Because the patient is taken out of his own familiar environment and hospitalized, "dying becomes lonely and impersonal."¹⁶ The patient may cry for rest, peace, and dignity; instead he will get transfusions, a heart machine, or tracheostomy, if necessary.

He may want one single person to stop for one single minute so that he can ask one single question -- but he will get a dozen people around the clock, all busily preoccupied with his heart rate, pulse, electrocardiogram, or pulmonary functions, his secretions or excretions but not with him as a human being.¹⁷

Clark Moustakas in his book Loneliness describes loneliness and separation as a condition of human life and

¹⁶Elisabeth Kübler-Ross, On Death and Dying, (New York: The MacMillan Company, 1969), p. 8.

¹⁷Ibid., p. 9.

human experience. According to Moustakas, "Every person as he grows experiences a sense of separation as a natural challenge to the development of individuality."¹⁸ Moustakas includes a lengthy discussion and study of the loneliness of the hospitalized child in his book. His study in this area of loneliness began with his own experience during the hospitalization of his child. The most serious threat to a child is the possibility of being abandoned or left alone. Although there are many kinds of temporary abandonment, the experience of having to be in the hospital alone is most desolating to a child.

The cold marble floors; the impersonal rules and regulations; the extreme bleak whiteness everywhere; the desensitized atmosphere; the neat, empty categorical arrangement of food and beds, external to the individual child and his personal preferences; the constant checks and routines; the frequent medication and shots which he does not comprehend; the disrespect for the integrity of his wishes and interests; the absence of genuine human warmth; and the presence of surface voices, surface smiles, and superficial words, and meetings; all enter into the loneliness of hospital life.¹⁹

Moustakas advocates the parents of a hospitalized child remaining with the child in every important experience

¹⁸Clark E. Moustakas, Loneliness, (New Jersey: Prentice-Hall, Inc., 1961), p. 35.

¹⁹Ibid., p. 36.

in the hospital until the child can decide himself if he is able to be alone. "The loneliness which the child experiences even when the parent is present is painful enough because in the end there are certain experiences which the child must face alone".²⁰

Moustakas condemns hospitals and hospital personnel for moving the parents of a child out of the way. Even if the feelings expressed toward the child by the nurse or physician are genuine, they "can never reach deeply enough to substitute for the love embedded in the child's relationship with his mother and father", and the nurse or physician will never be able to give the child the "feeling of safety and strength to face the severe trial of a painful illness". Moustakas further contends that "every nurse and doctor would want the parent to remain if he knew the meaning of the child's desperate existence when he lay in bed at night terrified and alone."²¹

Loneliness in the aged was studied and discussed in a paper by Irene M. Burnside. The paper, discussing the causes of loneliness in the aged and ways in which care-

²⁰Ibid., p. 38

²¹Ibid., p. 39.

takers of the aged can reduce this loneliness, was written while the author was receiving support from a USPHS Grant.

Burnside cites loneliness as a major problem in a sample of elderly people. Burnside believes that loneliness is low on the list of priorities of care for the institutionalized aged. "Physical care often has priority . . . "22

"Lonely aged," Burnside states, "like the dying patients, are frequently avoided". To become involved with the lonely aged in a hospital setting may necessitate behavior from the caregiver that is misconstrued, queried, and criticized as not professional by hospital personnel. Examples of this behavior given by Burnside are sitting quietly with the elderly patient, sharing beverages or food or even accepting small gifts. In her studies, Burnside has observed and listed seven factors contributing to loneliness in the aged. She states that one factor may outweigh others, but there may be several types of loneliness bearing down on the elderly person simultaneously. The factors this author lists are:

²²Burnside, op. cit., p. 392.

1) geographical loneliness; 2) language barriers; 3) cultural loneliness experienced by many foreign-born patients; 4) life-style loneliness; 5) loneliness of illness and/or pain; 6) loss loneliness; and 7) loneliness caused by impending death.²³

The hospitalized or institutionalized elderly patient may experience profound loneliness because several, or even all seven, of these factors may exist simultaneously. Burnside believes "if one decides that loneliness is a problem in an aged client or patient, then one needs to decide cause or causes (for they may be multiple) of that loneliness." From assessments of the causes of the loneliness, interventions can then be instituted which may be therapeutic for the patient. Burnside believes "the caretaker needs to creatively approach the mitigation of the aged's loneliness."²⁴

The investigator has discussed literature on the loneliness of the dying, the aged, and the hospitalized child. The loneliness described in these three areas may be correlated with change and how change affects a feeling of loneliness. In an application of transactional analysis to loneliness, Ira Tanner explains change and loneliness. "In a single sent-

²³Ibid., p. 393.

²⁴Ibid., p. 396.

ence: nothing living is ever the same from one minute to the next, and such change has an effect on our loneliness."²⁵

Hospitalization separates the patient from good friends, loved ones, and his familiar environment. "This separation and change can bring about an unexpected, sudden and bewildering experience of aloneness." "Separation from those we love deeply brings change . . . "²⁶ Separation from natural events, as in being hospitalized, can bring about a great loneliness and fear.

Tanner has found in his studies of his clients that the pain of loneliness can be more severe than actual physical pain.

Reflecting on its dogged, underlying persistence, a hospital patient commented, "Loneliness is always there, waiting to take over, and when it does it is really hard to get rid of. It takes work -- a real struggle, really fighting back."²⁷

²⁵Ira J. Tanner, Loneliness: The Fear of Love, (New York: Harper and Row, Publishers, 1973), p. 57.

²⁶Ibid., pp. 61-62.

²⁷Ibid., p. xii.

According to Dr. Tanner, saying "I am lonely" expresses a need for understanding and love. ". . . the opposite of loneliness is understanding. Nothing thaws loneliness more quickly than understanding."²⁸ In view of this statement, the investigator believes study into understanding and recognition of loneliness by the medical profession and by nursing especially, is indeed necessary.

In many articles on loneliness available in the literature, it is a recognizable fact that the loneliness of the mentally ill is profound. Frieda Fromm-Reichmann learned about loneliness in her work with schizophrenic patients. According to Fromm-Reichmann, loneliness is such a painful, frightening experience that people will do practically everything to avoid it. Avoidance of the condition seems to include reluctance on the part of psychiatrists to seek scientific clarification of the subject. Loneliness, therefore, is one of the least satisfactorily conceptualized phenomena, not even mentioned in most psychiatric textbooks. Dr. Fromm-Reichmann's impression, obtained from her own experiences with her patients and on the basis of many reports about other patients, is that loneliness and the fear of loneliness,

²⁸Ibid., p. 52.

on one hand, and anxiety on the other, are used many times interchangeably in psychiatric thinking and in clinical terminology. Fromm-Reichmann, in her studies, advises psychiatrists to learn to separate loneliness and anxiety. Psychiatrists will then learn to see that loneliness in its right plays a much more significant role in the dynamics of mental disturbance than psychiatrists have so far been ready to acknowledge.²⁹

Fromm-Reichmann postulates a significant inter-relatedness between loneliness and anxiety and suggests the need for further conceptual and clinical examination of loneliness in its own right and its relation to anxiety. Fromm-Reichmann expects that from such scrutiny, "it will be found that real loneliness plays an essential role in the genesis of mental disorder. Thus, I suggest that an understanding of loneliness is important for the understanding of mental disorder."³⁰

²⁹Frieda Fromm-Reichmann, "Loneliness", Journal for the Study of Interpersonal Processes, Vol. 21, No. 1, (February 1959), pp. 1-19. (from a reprinted paper).

³⁰Ibid., p. 19.

Chronically regressed schizophrenic patients were studied in group therapy by Madeline Gupta at the New York State Psychiatric Institute. Gupta made use of concrete objects as a means of promoting the beginnings of human relatedness in the group. The concrete objects Gupta used in her group to break through the wall of distance, isolation, and unrelatedness were such things as a tape recorder, an opaque plastic bag of common household objects, magazines, and newspapers, physical exercise, and paper and pencils. Gupta maintains in this study that "an understanding of profound loneliness is instructive as well as essential in the treatment of chronically regressed schizophrenic patients."³¹ Gupta agrees with Dr. Fromm-Reichmann that loneliness may have a disintegrative effect on the personality related to the deep uncommunicative and private emotional state, rendering persons emotionally paralyzed and helpless. The study of Madeline Gupta's use of concrete objects in a group of schizophrenic patients was successful in that the patients began to relate to each other and to her, and each experi-

³¹Madeline Gupta, "An Interruption in Loneliness: The Use of Concrete Objects in the Promotion of Human Relatedness," Journal of Psychiatric Nursing and Mental Health Services, (July-August, 1971), p. 23.

enced "relief from the devastating weight of isolation and silent agony and warmth toward the persons discovered in the group."³²

Marita DeThomaso studied the power of touch in breaking through the screen of loneliness. In her study, a mentally ill young girl is described and the turning point in a relationship, that occurred when the therapist touched the girls hair. The taboos on touch are discussed by De Thomaso and also the use of touch as a powerful form of communication -- a form that should be taken seriously and used with full awareness. The writing of DeThomaso warns that touch as a therapeutic measure with the lonely patient must be used judiciously. "To force touch on the lonely one before he is ready is to deprive him of a most valuable human experience."³³

DeThomaso's article and study is of importance in that it offers implications for nursing education. This author maintains that experiences are essential for developing awareness and understanding of the therapeutic use of

³²Ibid., p. 27.

³³Marita Tribou DeThomaso, "'Touch Power' and the Screen of Loneliness," Perspectives in Psychiatric Care, Vol. IX, No. 3., (1971), p. 116.

touch. "In the developing science of nursing, concepts as frequently encountered as touch and loneliness need to be explored scientifically as well as intuitively."³⁴ De Thomaso recommends providing experiential learning for young nursing students -- for example, in sensitivity group sessions.

In a study by Joanne Roberts, thirty enrollees in a graduate course at the University of Florida were given a questionnaire to answer. Fifteen of the thirty responded to the questionnaire by the deadline set. The questionnaire consisted of only three questions:

1. What is loneliness?
2. What do you think causes loneliness?³⁵
3. What has been your loneliest moment?

Some of the terms most frequently used in answering the first two questions were: separation, withdrawal, insecurity, absence, isolation, loss, deprivation, and unconcern.³⁶

Twelve of the responses to question three speci-

³⁴Ibid., p. 117.

³⁵Joanne M. Roberts, "Loneliness Is . . .", Perspectives in Psychiatric Care, Vol. X, No. 5, (December, 1972), p. 227.

³⁶Ibid., p. 229.

fically mentioned separation from a particularly significant other or others. The author mentions particularly that responses to question three were expressed in general terms, with no attempt to describe the depth of feeling encountered or how it was handled. This study indicates that after an episode of loneliness is over there is hesitancy to recall it -- perhaps for fear it may recur. Most significantly, the author states the study showed the need people have for others in avoiding loneliness.³⁷

In his book, The Lonely Crowd, David Riesman describes his inner-directed and other-directed people. Of interest to this investigator is that neither group of Riesman's escapes loneliness. Even in these two groups loneliness is not unique to just one group, is not an individual problem, but a national problem.

Of his inner-directed children, Riesman states that the fate of many is loneliness in and outside the home.

Home, school, and waystations between may be places for hazing, persecution, misunderstanding. No adult intervenes on behalf of the lonely or hazed child to proffer sympathy, ask questions, or give advice.³⁸

³⁷Ibid., p. 231.

³⁸David Riesman, The Lonely Crowd, (New Haven: Yale University Press, 1950), pp. 69-70.

Riesman says of the other-directed people that if they:

. . . should discover how much needless work they do, discover that their own thoughts and their own lives are quite as interesting as other peoples', that, indeed, they no more assuage their loneliness in a crowd of peers than one can assuage one's thirst by drinking sea water, then we might expect them to become more attentive to their own feelings and aspirations.³⁹

The tremendous fear of loneliness, described in most all the literature on loneliness, seems inherent in both of Riesman's groups.

One of the strangest things about loneliness is its paradox. You can be lonely without being alone. The loneliest type of loneliness is the kind you sometimes feel when you're with a crowd. And you can be alone without feeling at all lonely.

. . . being alone without the explicit condition of loneliness, is an act of conscious control, volition, thought and determination. Being alone is a necessary pause; being lonely is an ultimate condition. Being alone implies an evolution or continuity of experience, while being lonely means a total, radical change.⁴⁰

³⁹Ibid., p. 307.

⁴⁰Moustakas, Loneliness and Love, p. 22.

Harry Stack Sullivan outlines and describes developmental stages of the "ultimate condition" of loneliness. Sullivan's developmental stages leading to loneliness stress the need and importance of contact with others from the all-important stage of infancy, through childhood and adolescence. The need for interpersonal relationships, for intimate exchange with others, for contact and acceptance by others is the driving force for the relief of loneliness.⁴¹

About loneliness, Sullivan states:

Loneliness, as an experience which has been so terrible that it practically baffles clear recall, is a phenomenon ordinarily encountered in preadolescence and afterward.

Anyone who has experienced loneliness is glad to discuss some vague abstract of this previous experience of loneliness. But it is a very difficult therapeutic performance to get anyone to remember clearly how he felt and what he did when he was horribly lonely. In other words, the fact that loneliness will lead to integrations in the face of severe anxiety means that loneliness in itself is more terrible than anxiety.⁴²

⁴¹Harry Stack Sullivan, The Interpersonal Theory of Psychiatry, (New York: W.W. Norton and Company, Inc., 1953), p. 261.

⁴²Ibid., pp. 261-262.

From Sullivan's emphasis on the need for contact in alleviating loneliness, certain statements can be made about nursing contact with patients and the continuity of nursing contact with patients. In a paper written for a symposium on concepts in cardiac nursing, Mary Bielski elaborates on the need for continuity of care for the patient with coronary heart disease. In this paper, Bielski states:

Continuity of care is generally acknowledged by nurses as well as others on the health team as an essential component of health care services. Unfortunately, the consistency with which it is rendered remains less than satisfactory in too many instances

. . . . quality of care diminishes while its cost escalates. Personnel, time, and resources are utilized inefficiently and, what is more important, patients are made vulnerable to complications resulting from regimens of care improperly implemented and monitored.

Reasons for this breakdown in the continuum of care vary from lack of commitment to the inability to plan and to coordinate a plan of care.⁴³

Many nurses believe they can improve the quality of patient care if they have several successive days to

⁴³ Mary Bielski, "Continuity of Care for the Patient with Coronary Heart Disease," The Nursing Clinics of North America, Vol. 7, (September, 1972), p. 413.

familiarize themselves with the patient and to evaluate his responses to care. By assigning a nurse to the same patient for several days, the nurse can better assess those factors that are critical for the patient's improvement. Additionally, the patient will feel he has his own nurse at least for a few days in a row.

Many nurses have pointed out the advantages of scheduling personnel so as to provide for continuity of care. The assumption is that if a nurse provides daytime care for the same patient on several consecutive days, she will give better care to that patient on each successive day. The assumption seems to be based primarily on the desirability of forming base observations that provide opportunity for nurse-patient communications with some depth and breadth. Many nurses indicate that a patient would like to identify one nurse on the nursing staff as "his nurse."⁴⁴

Carl Rogers speaks of the loneliness that exists when a person feels he has no real contact with others. Rogers states that there are many contributing factors to this kind of loneliness.

. . . the general impersonality of our culture, its transient quality, its anomie -- all elements of loneliness which grow more marked the more we are crowded together. Then there is the fear, which resides in a great many people, of any close

⁴⁴ Price, op. cit., pp. 98-99.

personal relationship. These are a few of the factors which may cause an individual to feel he is closed off from others.⁴⁵

To summarize this review of literature on loneliness, the investigator feels compelled to say that although many articles on the topic of loneliness are available and increasing in scope, little research and study into loneliness is in evidence. From the literature, it is evident that loneliness can hurt and change people. Loneliness is an experience that all encounter some time in their lives. An understanding of the causes of loneliness and how it can be alleviated should be made aware to everyone, in this investigator's opinion. Loneliness dwells in our hospitals where the separation and uncertainty patients feel become lonely burdens to bear.⁴⁶ It is concluded here, by the investigator, that a study of the loneliness of hospitalized patients and the contact they receive from nursing personnel is not only relevant, but necessary.

⁴⁵ Carl Rogers, Carl Rogers on Encounter Groups, (New York: Harper and Row, Publishers, 1970), p. 107.

⁴⁶ Roberts, op. cit., p. 231.

CHAPTER III
METHODOLOGY, MEASURING INSTRUMENTS,
POPULATION DESCRIPTION AND SAMPLING PROCEDURE,
AND VARIABLES

METHODOLOGY

The problem of this research study was to determine the presence of loneliness in the hospitalized patient and the relationship between that loneliness and continuity of contact by nurses. A descriptive, non-experimental approach to the problem was employed to portray the characteristics of loneliness in the hospitalized patient and hospital staffing procedures regarding nursing personnel. The problem was studied from the patient's frame of reference about their feelings of loneliness relative to relationships with nurses and the care patients believed they received. Patients' feelings about hospitalization and nurse-patient relationships were obtained by means of a Patient Opinionnaire. Patients' opinions were then compared to answers given by nurses on a staffing questionnaire about continuity of contact by nurses on each ward where patients completed the opinionnaire. A follow-up interview to the opinionnaire was conducted with patients to elicit verbal responses on feelings of loneliness while hospitalized.

The Patient Opinionnaire:

The chief difficulty encountered in attempting to measure loneliness was the lack of a previously constructed and validated instrument. It was necessary, therefore, to construct an instrument specifically for purposes of this study.

Because loneliness can only be determined for each person and his experiences by the person himself, and because, perhaps the best way to learn about nurses' relationships with patients is to ask patients, an attitude or opinion measurement instrument was necessary for studying the problem of this study. A Patient Opinionnaire, patterned after the Q-sort technique, was the instrument designed to elicit patients' opinions.

The Q-methodology, described by Stephenson, proposes to study persons, and behavior, and attitudes rather than to study tests applied to persons and meant to measure abilities.⁴⁷ Q-methodology is the study of interpersonal relations. Applications of Q-methodology have been adapted to studies of classroom situations, clinical interactions studying leadership and many aspects of social psychology.

⁴⁷ William Stephenson, The Study of Behavior, (Chicago: The University of Chicago Press, 1953), pp. 15-16.

The Q-technique has been applied to nursing research to evaluate perceptions of interpersonal relationships by J. Frank Whiting.⁴⁸ According to Whiting:

In recent years, the literature on nursing and hospital care has emphasized the change in the nurse-patient relationship from one which was focused primarily on physical care to a broader relationship which also involves the psychological and social aspects of the patient as a human being.⁴⁹

Therefore, the Q-sort method of assessment of attitudes and opinions makes it a valuable tool in nursing research. The Q-sort is superior to the questionnaire, where the simple "yes" or "no" responses may be all that are elicited. The Q-sort method is also free from "I don't know" and completely omitted responses. Another advantage of the Q-sort in nursing research, as stated by Whiting is:

The simplicity of the technique, and the ease of its translation from one hospital setting to another allow for accurate inter-hospital comparisons.⁵⁰

Q-methodology begins with the formulation and development of items, or statements, originating from the

⁴⁸ J. Frank Whiting, "Q-Sort: A Technique for Evaluating Perceptions of Interpersonal Relationships", Nursing Research, Vol. 4, No. 2, (October, 1955), pp. 70-73.

⁴⁹ Ibid., P. 70.

⁵⁰ Ibid., P. 73.

theoretical framework established for the testing. Each item, or statement, is printed on a separate card and the number of statements and cards is determined by the theoretical framework and the researcher. The cards are then presented to the respondents who are asked to sort the statements into piles. Generally, there are from five to eleven piles, and the piles are arranged on a continuum of "most desirable" to "least desirable" categories; in other words, a continuum of importance as perceived by the respondents. The forced-choice method of sorting the statements is generally considered appropriate for the Q-sort. In the forced-choice Q-sorting, a symmetrical distribution of the items is obtained by having the number of items to be sorted in each pile fixed by the investigator.⁵¹ Each card, or statement, is assigned a number, for example, sixty cards numbered one to sixty, to aid in arranging the sorted data for statistical analysis.

The Construction of the Instrument:

The instrument developed for testing patients

⁵¹ Bernadine Irwin and Janet R. Meider, "Supportive Measures for Relatives of the Fatally Ill", Communicating Nursing Research, (Western Interstate Commission for Higher Education: Colorado, December, 1973), p. 122.

about their hospital experiences was a modified Q-sort technique. The use of a modified Q-technique, administered by the investigator, had certain advantages over a questionnaire method or a strictly interview situation for the purpose of this study.

The questionnaire method is advantageous in the areas of being a less expensive procedure; of ease in administration to large numbers of individuals; of standardized wording and order of questions for ensuring uniformity from one measurement situation to another; of placing less pressure on the respondents for immediate response; and, of respondents, having greater confidence in their anonymity, feeling freer to express their views.

The interview is an appropriate technique for revealing information about complex, emotionally laden subjects or for probing the sentiments that may underlie an expressed opinion. The interview is also flexible in that misinterpretation of questions or statements can be rephrased or repeated to ensure understanding by respondents.

The Patient Opinionnaire developed for this study combined the advantages of the questionnaire and interview methods. The Patient Opinionnaire contained instructions for completion of the task which were concise and simple to

understand. In addition, the investigator was present to further clarify the instructions. At the completion of the entire opinionnaire, the investigator conducted an interview with the respondents which included a question about patients' feelings of loneliness while hospitalized. The data gathered from the Patient Opinionnaire were analyzed for statistical interpretation. The opinionnaire statements are presented in Appendix B. The verbatim responses of patients received during the interview were compared to the way patients responded on the opinionnaire and are included in the study in Appendix H.

The Patient Opinionnaire contained statements which were classified into five broad areas of relating to nurse-patient interaction and features of total nursing care. The five areas, with the numbers of the statements included in each area, were:

1. A general area containing statements personal to the patient confined in a hospital. Statements related to visitation by patients' families and friends; patients' time spent sleeping, thinking, or watching television; if the patient is left to pass the time in whatever way he can; and, the patients' independence while hospitalized. (Refer to Appendix B, statements 1, 2, 3, 4, 5, 6, 20, 23.)

2. An area containing statements about the interpersonal aspects of nursing care the patient receives. These statements referred to the nurse explaining tests, procedures, examinations, and the meaning of these things to the patient; the nurse discussing the patients' future or home care with him; informing the patient about aspects of his illness pertinent to him; and, the hospital environment, in general. (Statements 8, 9, 19, 22, 24)

3. An area containing statements of patients' perceptions of how they are treated by nurses; their relationships with nurses; and, humanistic aspects of the nurse-patient helping relationship. (Statements 7, 10, 11, 16, 18, 21, 26, 27.)

4. An area of statements relating to continuity of contact by nurses. The cards in this area were statements about the patients' knowing who the nurse on duty would be from day to day; when one nurse went off duty and another took her place; who his nurse was; if the nurse was close-by; and, having the same nurse each day or a variety of nursing personnel. (Statements 12, 13, 15, 17, 28, 29.)

5. An area of statements relating loneliness to many personnel coming and going in the patients' rooms. (Statements 14, and 25.)

Three authors and their writings about loneliness and about interpersonal relationships were especially meaningful in the development of the statements used in the opinionnaire. Most helpful were these authors' referrals to nurse-patient relationships which either related directly to loneliness or could be correlated with loneliness. The authors were Carl Rogers,⁵² Esther Lucile Brown⁵³ and Sidney Jourard.⁵⁴ Sidney Jourard, in writing of self-disclosure and the need for man to make himself known, applies self-disclosure to the nurse-patient relationship. Jourard writes that a patient can be inspired with faith and hope by knowing that somebody cares about him. According to Jourard, the quality of the nurse-patient relationship is a factor in the patient's recovery. He states:

Direct contact with a patient somehow increases his sense of being a worthwhile individual person, and this experience inspires him -- it does something to the body which helps it throw off illness.⁵⁵

⁵² Rogers, "Characteristics of a Helping Relationship", loc. cit.

⁵³ Brown, loc. cit.

⁵⁴ Sidney M. Jourard, The Transparent Self, (New York: Van Nostrand Reinhold Company, 1971).

⁵⁵ Ibid., p. 206.

In addition, other authors whose writings contributed to the development of the statements for the opinionnaire were Clark Moustakas, Elmina Price and Marie Manthey. These writers have been cited in foregoing chapters. The statements, then, were representative of the literature on loneliness and interpersonal relationships in the hospital.

The consultation of a professor qualified in testing and statistics was obtained. From his recommendations, it was decided to administer the opinionnaire to each patient twice, using two sets of statements. The statements were then written to encompass two situations. The first set of statements were written as the ideal hospital situation. These statements all began with the words "I like..." and were called the Ideal. They were written to represent what the patient likes or wants while hospitalized, or how he would like the hospital environment to be ideally. The second set of cards were written similarly to the first set, but omitting the words "I like. .". This set of statements were written to represent how the hospital setting really exists for the patient, contrasted with the Ideal, and were labeled the Actual. Each statement was numbered and typed on a separate card.

The statements were reviewed by the investigator

and other nursing professionals and repetitious items, items that were difficult to understand and items that were not representative of the purposes of the study were omitted. The final number of statements was fifty-eight, twenty-nine statements in each of the two categories.

Patient Opinionnaire Sorting Categories:

Five categories were established into which the cards (statements) were sorted. The five categories were established as answers to the statements on a continuum of time; in other words, how often the situation presented on each card existed ideally or actually for the patient. Two extremes of time were established, Never and Always. A middle category of these two extremes was labeled At Times. Two other categories were then determined; one intermediate of Never and At Times, labeled Rarely, and one intermediate of Always and At Times, labeled Often. The five categories, then, for sorting the statements were:

1. Never (not at all, not ever)
2. Rarely (seldom, infrequently)
3. At Times (sometimes, occasionally)
4. Often (frequently, many times)
5. Always (a lot, at all times)

The words in parentheses were added to clarify and give further meaning to the main word categories.

Each statement was given the "score" of the number of the category in which it was placed by the respondent.

In order to facilitate sorting of the cards by the respondents, a Patient Opinionnaire Guide was devised. On a poster board, cut to the measurements of the patients' overbed tables, the categories were arranged on a continuum 1 to 5. The number of each category and the identifying time words for each category were boldly printed beneath a square drawn to the size of the statement cards. The sorting board provided an attractive and easily understandable guide for patients completing the opinionnaire. The design of the Patient Opinionnaire Guide is presented in Appendix C.

Directions to patients for completion of the opinionnaire were typed on one page and were presented clearly and concisely. The investigator was also present when patients read the directions to further clarify any misunderstanding in completing the opinionnaire. The directions that were given to patients to read are presented in Appendix A.

It must be restated here that the testing instrument developed for this study was not a Q-sort, as such, but was patterned after the Q-technique.

Pilot Testing of the Instrument:

The opinionnaire was initially tested on nurse classmates and also on non-nursing people as a check for clarity and understanding of the statements, the Opinionnaire Guide, and the instructions to the patient for completing the opinionnaire. No changes were found to be necessary in the format of the testing instrument or in the statements.

A pilot study was then conducted at one of the five hospitals of the study. Five patients were selected according to a specified sampling procedure and after these patients agreed to be part of the study, they were given the Patient Opinionnaire to complete.

Following the completion of the opinionnaire and interview about loneliness in the hospital, the five patients were asked their opinion regarding the testing instrument. The format of the testing instrument and the statements of the opinionnaire were not changed or revised following the pilot study and interviews; however, some of the variables inherent in the study became apparent after the pilot study. The variables of the study will be discussed at the end of this chapter. The five patients of the pilot study were then included in the total sample.

Population Description and Sampling Procedure:

The sample for this study was drawn from a population of patients from five selected hospitals in Montana. The five hospitals were located in three different cities in Montana. The sample of patients was drawn from several hospitals to obtain a larger number of patients to which generalizations may be applied. The hospitals are all general hospitals caring for medical, surgical, obstetrical and pediatric patients. No general hospital in Montana exceeds a 250 bed capacity. Hospital bed capacity ranged from 123 to 197 in the hospitals sampled.

A cover letter introducing the investigator, explaining the purpose of the study, and requesting permission to carry out the study was sent to the Director of Nursing Service in each hospital in advance of the data collection. Samples of the letters sent to Directors of Nursing Service in the five hospitals are Appendices F and G.

The method of obtaining the sample was devised prior to collecting the data. The sample was limited to oriented, adult medical-surgical patients hospitalized for active treatment of an illness. Patients hospitalized solely for purposes of undergoing physical examination and testing procedures were delimited from the study. Patients assigned

a private duty nurse, pediatric patients, patients requiring isolation procedures, and patients too ill to complete the measuring instrument were delimited from the study.

The ideal procedure established by the investigator for obtaining the selected sample was devised as follows:

- A) All hospital nursing service departments maintain a census sheet or a census card-index which includes the name, age, diagnosis, and general condition of each patient.
- B) From each nursing service census form, a list would be made of all the medical-surgical patients not excluded by the delimitations of the study.
- C) From each list, every fifth individual would be selected for the sample. Nursing service census lists would be re-counted for every fifth patient, eliminating the patients of the previous counting until the investigator obtained a sample list of a minimum of twenty patients.
- D) The investigator would participate in and supervise the systematic sampling procedure.

E) Patients on the sample list would then be asked to participate in the study and complete the Patient Opinionnaire.

Difficulties were encountered by the investigator in adhering strictly to the sampling procedure devised because of individual differences in hospitals. Consequently, the prospective sample list from each hospital was obtained as follows:

Hospital A: The Inservice Director examined the hospital census sheet and crossed off the names of patients delimited from the study. Then, every fifth patient was counted and added to the prospective list of patients.

Hospital B: The prospective list of patients was obtained by using the nursing station card-indexes of patients from two medical wards and one surgical ward. As much as possible, every fifth individual in the card index was selected for the list.

Hospital C: Close adherence to the established sampling procedure was possible in this hospital. From indexes in the nursing service office, patients from two medical wards, two surgical wards, and one medical-surgical ward were selected for the list before going to the specific wards.

Hospital D: A sample list of patients was obtained in the nursing service office from card indexes of two medical wards, a medical-surgical ward and an orthopedic ward. The set sampling procedure was followed.

Hospital E: Because of the floor plan of this hospital, all the patients completing the opinionnaire were assigned to one floor, considered a medical-surgical ward. Patients were selected, as much as possible, according to the sampling procedure from the ward's nurses station card indexes. This particular hospital ward is an entire floor with a bed capacity for 55 patients. On the particular day testing was conducted at the hospital, the patient census on this ward was 23 patients. Two patients from the list declined to be a part of the study. A total sample of 10 patients was obtained which the investigator believes was a representative sample of patients from that ward on that particular day.

The total sample from all five hospitals on which the data were analyzed was sixty-four patients. The samples from each hospital were:

- A) 11 patients (includes the five patients of the pilot study.)
- B) 15 patients

C) 14 patients

D) 14 patients

E) 10 patients

Although the prospective lists obtained for the sample were larger than the final sample size, it must be remembered that many patients declined to be part of the study..

Method of Data Gathering:

Patients in the sample, after giving their permission to be part of the study, were given the instructions for the opinionnaire and further instructions, as necessary. Patients were then given the set of cards labeled the Ideal to sort on the opinionnaire Guide. The patient was then left alone to sort the first set of cards. When the Ideal set of cards was sorted according to the patient's opinion, the investigator returned, wrote the number of each statement on the data tabulation sheet in the category in which the patient placed it on the Guide, gave the patient the set of cards labeled the Actual and again left the patient alone to sort the second set of cards. The investigator again returned, and wrote the number of the statements sorted by the patient on the tabulation sheet under the categories

which the patient chose.

The interview, which followed completion of the opinionnaire, included three questions as a follow-up to the opinionnaire. The questions asked of patients were:

1. Have you felt lonely while in the hospital?
2. If so, can you name or specify a cause for your loneliness in the hospital?
3. Is this your first time in the hospital?

Verbatim responses of patients to these questions were recorded on the patient data sheet.

Also included on the patient data sheet was information about the patient who completed the opinionnaire and the hospital where the testing took place. Each patient was assigned a number for purposes of record keeping. Further patient data included the sex of the patient, age, diagnosis, and the number of days the patient had been hospitalized.

The five hospitals of the study were each assigned a code letter. The hospitals were A, B, C, D, E. Hospital A was in one Montana city and was the hospital of the pilot study. Other patients were tested at hospital A in addition to the five patients of the pilot study. Hospitals B and C were both located in one of the larger cities in Montana. Hospitals D and E were both located in a third Montana city.

The hospital code letter was included on the patient data sheet and also the ward where each patient was administered the opinionnaire was included. The wards were recorded as medical, surgical, or in cases of a combination, medical-surgical. A sample of the opinionnaire tabulation sheet, patient data and verbatim response sheet is presented in Appendix D.

Method of Defining Loneliness for the Patient Opinionnaire:

The review of literature presented in Chapter II and other literature cited in this study considers loneliness as an experience which exists for a person when certain needs are not met; in other words, when there is a discrepancy in what is occurring or happening to a person and what he desires. Loneliness, then, can be experienced by an individual when he wants, seeks, or needs human contact and does not have that contact or for some reason he chooses not to reach out for that contact. Loneliness can occur when a person is surrounded by people but feels uncared for, lost, or misunderstood. Loneliness can occur for the hospitalized patient when the treatment he desires as a patient and a human being is not what he actually receives.

Loneliness was defined for the purposes of data analysis as the discrepancy that became apparent when the patient completed both the Ideal sorting of the cards and the Actual sorting of the cards.

If the patient sorted the Ideal statements into the Often and Always categories on the Opinionnaire Guide, and then sorted the Actual statements into the Rarely and Never categories, the difference, or the discrepancy between the two sortings was defined as loneliness.

Only one set of statements actually contained the word "lonely." Card 25 was stated as follows:

Ideal: I like many different hospital personnel coming and going in my room so I will not feel lonely.

Actual: I am lonely even though many hospital personnel and people are coming and going in my room.

This particular set of statements were so stated to test Esther Lucile Brown's premise that the numbers of people entering and leaving a patients room accentuate the loneliness of the patient.⁵⁶

⁵⁶ Brown, loc. cit.

The Questionnaire for Nursing Care/Staffing Policies:

A simple, brief, one page questionnaire was developed to examine nursing staffing on the wards where patients were tested. The questions asked what approach to nursing care was in operation on the ward; if the ward was staffed by a regular or steady staff of registered nurses; how often "float" nurses were employed on the ward; and, if nurses employed on the ward were rotated from team to team or, in the case of functional nursing, rotated from position to position. In addition, the definition of continuity of nursing contact was given on the questionnaire and nurses were asked, in their opinion, if the patients on their particular ward were provided with continuity of nursing contact.

The questionnaires were completed by head nurses or charge nurses on duty on wards where patients completed the opinionnaire. The hospital code letter and the type of ward were written on the questionnaire. The complete questionnaire is presented in Appendix E.

VARIABLES

1. No control over hospital census at the time of the testing was possible. In some instances hospital census' were low which limited selection of the sample. Sample size was

further limited due to pre-set delimitations.

2. There was little control over the hospital environment while patients completed the measuring instrument. Privacy, as much as possible, for the patient during administration of the measuring instrument was attempted; however, interruptions occurred.

3. It was found necessary to depart, at times, from the established sampling procedure due to discrepancies between hospitals. The study was limited to a modified, selected sample of patients.

4. Two possible variables were due to the presence of the investigator:

- 1) Loneliness is a difficult and often fearsome experience to discuss. The presence of the investigator could have influenced patients' responses such that patients would not or would not be able to discuss their true feelings about loneliness with a stranger whose time with them was limited.
- 2) The fact that the investigator did spend time with patients during the explanation of the study and the instructions, the tabulation of their responses on the opinionnaire, and while

conducting the interview, and the fact that for a time, the opinionnaire offered patients a way of passing some time and a novel way of expressing themselves, could possibly have been an interruption in loneliness, if loneliness did exist for the patients.

5. The investigator personally conducted the administration of the opinionnaire and interviews on fifty patients of the sample obtained. Data were gathered on fourteen of the sixty-four patients by a Montana State University nursing student. Four of these fourteen patients were from Hospital B and ten of the fourteen were from Hospital C.

6. The investigator was not able to control, at the time of data gathering, individual patient factors which would cause responses to the opinionnaire to vary. Among those factors which patients stated affected their responses were: improvement of their condition prior to testing, receiving negative test results prior to testing or anticipation of test results, length of hospital stay, or anticipation of dismissal from hospital.

CHAPTER IV

ANALYSIS OF DATA

A total of 64 patients constitute the sample on which data were computed and analyzed. Of the 64 patients who completed the opinionnaire, 36 were male patients and 28 were female. The age of the sample ranged from 20 to 81 years of age. The mean age for the sample was 48.38 years; the median age was 50 years.

Length of hospitalization ranged from one day to 110 days. The average length of hospitalization, which did not include the one patient hospitalized for 110 days, was 7.8 days. For three of the sixty-four patients, it was their first hospitalization.

The statements of the opinionnaire were matched pairs. A pair of statements was the Ideal statement and its corresponding Actual statement; eg., Ideal statement I and Actual statement I were a pair.

A score was determined for each pair of the twenty-nine pairs of statements on each of the 64 patients. The score for each pair of statements was the difference, or discrepancy, between the number of the category on the opinionnaire guide where the Ideal statement was placed and the number of the category where the Actual statement was placed. For example, if Statement #1 from the Ideal was placed in the

5 (Always) category, and statement #1 from the actual was placed in the 2 (Rarely) category, when the score for that pair of items was 3. The score of 3 was the discrepancy, defined as loneliness, between the patient's ideal hospital treatment and the treatment actually received.

If there was no difference between the placement of an Ideal statement and its corresponding Actual statement, the score for that pair of items was 0 (zero). In the case of a 0 (zero) score, the patients' actual care was what he wanted or expected, and in that case, no discrepancy occurred. A 0 (zero) score was theorized as the "perfect score" for indicating an absence of loneliness.

During tabulation of the scores for each pair of statements, exceptions to the 0 (zero) "perfect score", indicative of an absence of loneliness, were discovered with statements 22, 23, and 25.

These particular statements were taken almost directly from the literature⁵⁷ and because of the manner in which these statements were phrased, the "perfect score" for these items indicating no discrepancy or loneliness was not 0 (zero).

⁵⁷Brown, op. cit., pp. 20, 22.

The greatest discrepancy for items 22 and 23 occurred when the Ideal statement was placed in the 5 (Always) category on the opinionnaire guide and the corresponding Actual statement was also placed in the 5 category -- yielding a 0 (zero) score. A "perfect score" for statements 22 and 23, indicative of an absence of loneliness was 4.0. This score meant that the Ideal statement was placed in the 5 (Always) category on the opinionnaire guide and the corresponding Actual statement was placed in the 1 (Never) category.

Statements 22 and 23 were typed on the cards as:

<u>Ideal</u>	<u>Actual</u>
22.) I like being informed about my illness and the meaning of things that are done to me.	22.) I feel lost because I have a minimum of information about my illness and the meaning of things that are done to me.
23.) I like having something to do to help pass the time while in the hospital.	23.) I feel bored because I am left to pass the time in whatever way I can.

In the case of statement 25, the greatest discrepancy occurred with the placement of the Ideal card in category 1 (Never) on the opinionnaire guide and the placement of the Actual card in category 5 (Always) which produced a score of - 4.0. A + 4.0 score for item 25 meant the Ideal statement was placed in category 5 (Always) and

the Actual statement was placed in category 1 (Never), indicating absence of loneliness. Item 25 was stated as:

<u>Ideal</u>	<u>Actual</u>
25.) I like many different hospital personnel coming and going in my room so I will not feel lonely.	25.) I am lonely even though many hospital personnel and people are coming and going in my room.

The significance, for purposes of the study, was in the amount of discrepancy between the statement pairs; in other words, the greater the discrepancy between the Ideal hospital situation and the Actual situation, the greater the patient loneliness. (except for statement pairs 22, 23, and 25 as explained).

The score obtained as the difference between the placement of the Ideal statement and the Actual statement was termed the discrepancy score.

The twenty-nine discrepancy scores for each patient, along with patient information data, were coded and copied on coding forms. The coded forms were then keypunched and submitted for computer analysis.

The twenty-nine scores for each patient in the sample of 64 patients were tabulated by the computer to find the mean for each of the twenty-nine pairs of items. The analysis of data from the Patient Opinionnaire, then, was according to the mean discrepancy score of each of the twenty-

nine items. The computerized mean discrepancy scores ranged from a -0.8 to a +2.0. There was only one mean discrepancy score of 0 (zero). Table I shows the frequency of the mean discrepancy scores and their corresponding item description in order of magnitude.

The table shows that eight items were below the "perfect score" of 0 (zero), one item was at 0, and twenty items ranged from +0.1 to +2.0. For purposes of this study an arbitrary figure of +0.5 was set as the level of significance. This figure was set because a close examination of those statements, whose mean discrepancy scores were in the range of -0.5 to +0.5, showed little, and in some cases no discrepancy between the Ideal and the Actual on the opinionnaire tabulation sheets of the 64 sample patients. Any mean discrepancy score of more than +0.5 level was determined as being the state of loneliness. An exception to this state was in the mean discrepancy scores of items 22, 23 and 25.

As seen in Table I, the mean discrepancy scores for items 1 through 4, 6, 7, 11, 13, 14, 16, 17, 18, 20, 21, 24, 26, 27, and 29, all fell within the +0.5 to -0.5 range. In terms of the definition of loneliness for purposes of analysis, as being the amount of discrepancy between the Ideal

TABLE I. Frequency of Mean Discrepancy Scores

No.	Item	Discrepancy (Difference)
22	Being informed about illness.	2.0 *
23	Having some way of passing time.	1.6 *
19	Knowing <u>meaning</u> of tests, procedures.	1.5
25	Many hospital personnel/loneliness.	1.1 *
12	Knowing who nurse will be, day to day.	0.8
8	Nurse explaining procedures.	0.8
9	Nurse discusses future care plans.	0.7
29	Having same nurses every day.	0.5
18	Nurse cares for patient as a person.	0.5
4	Thinking alone.	0.5
26	Nurse is like a friend.	0.4
21	Nurse recognizes <u>person</u> , not illness.	0.4
16	Nurse encourages patient expression.	0.4
20	Patient retains independence.	0.3
13	Patient has "His Nurse".	0.3
11	Nurse sympathetic to patient.	0.3
24	Hospital environment warm, personal.	0.2
17	Patient sees nurse is close-by.	0.2
7	Nurse spends time talking to patient.	0.2
3	Patient watches TV alone.	0.1
6	Patient undisturbed by nurses.	0.0
1	Visitation by family.	- 0.1
14	Many personnel visit room.	- 0.2
2	Visitation by friends.	- 0.3
27	Patient says what's on his mind.	- 0.3
10	Nurses <u>listen</u> to patient.	- 0.6
28	Patient knows when nurse leaves.	- 0.7
5	Patient able to sleep.	- 0.8
15	Variety of nurses on the ward.	- 0.8

* Mean discrepancy scores of these items not representative of significance, according to the Table. See analysis discussion.

hospital situation and the Actual hospital situation, the interpretation was that there was no significant loneliness in the areas encompassed by these particular statements.

The discussion earlier in this Chapter explained that items 22, 23 and 25 were exceptions to the terms of analysis established for the other items in Table I. The mean discrepancy scores of 2.0, 1.6 and 1.1 for items 22, 23 and 25 respectively were interpreted as showing no significant discrepancy.

A hand tabulation of items 22, 23 and 25 revealed the categories of the opinionnaire guide into which the majority of the statements were sorted by patients as shown on Table II.

Esther Lucile Brown's premise that many hospital personnel coming and going in patients' rooms accentuated loneliness did not appear to be the case in this study.⁵⁸ The statements from the area established for statements relating loneliness to many personnel coming and going in patients' rooms (Items 14 and 25) were not significant.

Items Above the +0.5 Level:

Table I shows items 9, 8, 12 and 19 above the +0.5 level of significance. Item 9, with a +0.7 mean discrepancy

⁵⁸Brown, op. cit., p. 22.

TABLE II. Tabulation of Statements 22, 23 & 25.

STATEMENT 22

	<u>Ideal</u>	<u>Actual</u>
Number of	47 (5, Always)	20 (1, Never)
Cards in Categories	12 (4, Often)	21 (2, Rarely)
	<u>4</u> (3, At Times)	<u>10</u> (3, At Times)
TOTAL	63	51

STATEMENT 23

	<u>Ideal</u>	<u>Actual</u>
Number of	21 (5, Always)	19 (1, Never)
Cards in Categories	16 (4, Often)	21 (2, Rarely)
	<u>22</u> (3, At Times)	<u>15</u> (3, At Times)
TOTAL	59	55

STATEMENT 25

	<u>Ideal</u>	<u>Actual</u>
Number of	3 (5, Always)	23 (1, Never)
Cards in Categories	13 (4, Often)	23 (2, Rarely)
	20 (3, At Times)	11 (3, At Times)
	21 (2, Rarely)	6 (4, Often)
	<u>7</u> (1, Never)	<u>1</u> (5, Always)
TOTAL	64	64

is significant for purposes of this study. Item 9 states:

<u>Ideal</u>	<u>Actual</u>
9.) I like the nurses to discuss plans for my future (or home) care with me.	9.) The nurses discuss plans for my future (or home) care with me.

The 0.7 mean discrepancy indicated that nurses did not, as a rule, discuss plans for future or home care with patients, although that is what patients wanted, ideally.

Item 8 and 12 were significant, in this study, with both items scoring a 0.8 mean discrepancy. Items 8 and 12 were:

<u>Ideal</u>	<u>Actual</u>
8.) I like the nurses to explain procedures of my care to me so I understand them.	8.) The nurses explain procedures of my care to me so I understand.
12.) I like to know who the nurse on duty will be from day to day.	12.) I know who the nurse on duty will be from day to day.

A 0.8 mean discrepancy is nearly one full degree from 0 (zero). According to the mean discrepancy score of Item 8, nurses did not explain procedures of care to patients' understanding; therefore, patients felt lonely and alienated in this area. Item 12 was classified in the general area of statements relating to continuity of contact. With the 0.8 mean discrepancy for this item, the interpretation was that a

lack of continuity of contact was present in that patients did not know who the nurse on duty would be from day to day.

Item 19 with a mean discrepancy of 1.5 showed the highest degree of discrepancy of all items. It was interpreted as the area of greatest patient loneliness. Item 19 was:

<u>Ideal</u>	<u>Actual</u>
19.) I like to know the <u>meaning</u> of the tests, examinations and procedures that are given to me.	19.) The nurses explain the <u>meaning</u> of the tests, examinations and procedures that are given to me.

The 1.5 score indicated that patients were not informed of the meanings of things they would like to know. Not knowing or understanding the meaning of tests given them can cause the patient anxiety and loneliness ⁵⁹ in the area of interpersonal relationships with nurses.

Items Below the -0.5 Level:

Table I shows items 5, 10, 15 and 28 below the -0.5 level of significance. A negative discrepancy occurred when Ideal statements were placed in lower number categories on the Opinionnaire Guide than the corresponding Actual statements.

⁵⁹Brown, op. cit., p. 20.

Item 10, with a mean discrepancy score of -0.6 is only 0.1 degree from the -0.5 level of significance.

Item 10 on the opinionnaire was:

<u>Ideal</u>	<u>Actual</u>
10.) I like the nurses to take time to <u>listen</u> to me, when I feel like talking.	10.) The nurses take time to <u>listen</u> to me when I express my feelings.

The fact that the patients placed the Ideal portion of this statement lower on the continuum of opinionnaire categories than the placement of the Actual portion was interpreted to mean that patients did not feel like talking or were not able to talk and express feelings even though the nurses might take time to listen. Loneliness would exist, then, in this situation when the patient "remains silent and withdrawn though surrounded by people . . ." ⁶⁰

Item 28 had a mean discrepancy computed as -0.7:

<u>Ideal</u>	<u>Actual</u>
28.) I like to know when one nurse will be leaving for the day and another will take her place.	28.) I know when the nurse leaves for the day and another one takes her place.

⁶⁰ Moustakas, Loneliness and Love, p. 50.

Statement 28 was classified in the area of continuity of contact. Placement of the Ideal statement in lower sorting categories than the Actual indicated that patients did not place a high degree of importance on this aspect of continuity of contact.

Statement 5 had a mean discrepancy, as indicated in Table I, of -0.8. Statement 5 on the opinionnaire was:

<u>Ideal</u>	<u>Actual</u>
5.) I like to sleep a great deal.	5.) I am able to sleep when I want.

The interpretation of the score for this particular statement was that patients placed less emphasis on liking to sleep than they did on being able to sleep when they wanted. Although this statement was a -0.8 and nearly one degree, negatively, from the "perfect score" of 0 (zero), the -0.8 for this statement appears of no significance.

Item 15 and its mean discrepancy score of -0.8 does show high significance. Item 15 was presented on the opinionnaire as:

<u>Ideal</u>	<u>Actual</u>
15.) I like a variety of nurses to take care of me . . . for instance, a different nurse each day.	15.) There are a variety of nurses and personnel on this ward . . . perhaps a different nurse each day.

The -0.8 mean discrepancy for this statement appears highly significant in the area of continuity of contact. The Ideal statement was placed in lower sorting categories indicating that patients did not like a variety of nurses or different nurses each day. The Actual statement was placed in higher sorting categories indicating that perhaps different nurses or a variety of nurses cared for the patients each day and, therefore, a degree of lack of continuity of contact by nurses was present.

Analysis of the Nursing Care/Staffing Policies Questionnaire

Nursing Care/Staffing Policy questionnaire (Appendix E.) were completed on a total of 17 medical/surgical wards where patients completed the opinionnaire in the five hospitals.

Functional nursing was in operation on 5 of the wards. Team nursing was in operation on 11 of the wards; however, one medical ward reported a modified team approach. On another medical ward, the nurse reported that, depending on staffing, the functional approach to nursing care was generally in operation. When staffing was limited, or patient census was low, answer C., question 1, on the questionnaire was in operation. This nurse circled "Other" as

that particular ward's approach to nursing care.

Sixteen of the medical/surgical wards reported they had a regular, or steady, staff of registered nurses. One ward reported it did not.

Sixteen of the wards' head nurses, or charge nurses, stated, in their opinion, patients received continuity of nursing contact. The charge nurse on one ward answered that question "no".

To the question about staffing the wards with float nurses, the head nurses and charge nurses answered:

Yes, daily,

Several times a week.

Float nurses on night shift.

Float nurses frequently on afternoon shift.

Float nurses most often on day shift.

Float nurses approximately six times a month.

Float nurses only as replacements for someone ill.

Float nurses as relief for assigned nurse.

Two days a week.

Approximately three days a week.

Other replies were, simply, "no".

One charge nurse reported that nurses floating to her ward was not the problem. The problem, as she reported

it, was that due to consistent low patient census on her ward, personnel from that ward were "floated" or assigned elsewhere in the hospital where patient census was higher.

Only one ward where functional nursing was in operation reported nurses were rotated from position to position; and that was reported as "several times a week" on a surgical/orthopedic ward.

The head nurses on three wards where team nursing was in operation reported that the nurses were not rotated from team to team. Five wards with team nursing in operation reported nurses were rotated from team to team every week. One ward reported nurses on the teams were rotated every one to two weeks; and two other wards employing team nursing, reported team nurses were rotated every month.

The general opinion of the nurses on wards where patients were tested was that: there was a regular staff of registered nurses; float nurses were assigned to the wards infrequently, and usually as relief nurses when regular nurses had days off; nurses on wards with functional nursing were not rotated from position to position, except in rare instances; however, nurses on 6 of the 11 wards with team nursing were rotated from team to team every 1 or 2 weeks.

Sixteen of the seventeen wards reported definitely that patients on those wards received continuity of nursing contact.

The Hospital Ward Without Continuity of Nursing Contact

Two patients completed the opinionnaire on the one ward which reported a lack of continuity of nursing contact.

The two patients' opinionnaires showed no discrepancy between Ideal and Actual statements on items 8, 9, 12, and 19. These were the items on Table I. that showed the highest significance of the mean discrepancy scores for the entire population.

Both patients' opinions were that they were informed about their illness (Statement 22). One of the patients reported being bored "at times"; the other patient "never" (Statement 23).

On Item 25, regarding loneliness, one of the patients placed the Ideal card in the 3, At Times, category and the Actual card in the 5, Always, category. However, when the patient was asked the follow-up question on loneliness, he replied, simply, "no".

The second patient placed item 25 of the Ideal in the 2, Rarely, category and the Actual card in the 3, At Times, category. This patient's reply to the follow-up

question on loneliness was: "Just one day -- one afternoon was really bad. There were so few patients here and it was so quite -- like no one was around."

The patients were both male patients, ages 34 and 59. Each had been hospitalized at least 15 days, and both had been hospitalized for serious medical problems.

This particular ward was significant in the study in that it was the only ward which reported a lack of continuity of contact and both patients tested on this ward expressed a degree of loneliness, both by means of the opinionnaire, and one verbally.

Comparison of Opinionnaire Results and Patients Verbatim Responses to Loneliness

Statement 25 of the Opinionnaire was compared to patients' verbal responses to the question of loneliness.

Tabulation of the Actual portion of Statement 25 revealed that 23 patients replied they were "never" lonely and 23 patients replied they were lonely "rarely". Eleven patients replied to statement 25 that they were lonely "at times" and 6 patients experienced loneliness "often". Only one of the sixty-four patients placed the Actual portion of Statement 25 in the "Always" category.

Verbal responses of patients to the question of their feelings of loneliness were often contradictory to the placement of Statement 25. The one patient who placed Statement 25 in the "Always" category replied "no" to the verbal question about loneliness.

A patient who placed Actual statement 25 in the "never" category replied to the verbal question:

In the evenings it gets lonely. I don't like TV and I just wish there was something to do. There aren't enough nurses on duty to be able to visit every-one or visit a lot. But there's a lot of people who don't have company and could use someone to talk to. I'd like to get up and go talk to everyone.

Five patients who placed the Actual portion of statement 25 in the "often" or "at times" categories on the patient opinionnaire guide replied "no" to the question of loneliness during the follow-up interview.

One patient placed statement 25 in the "often" category but verbally referred to loneliness in the third person:

I think there is a lot of loneliness in the hospital. But for me - I just want to feel better and go home.

Two patients sorted statement 25 into the "At Times" category and during the follow-up interview replied "yes", and "yes, definitely", to the question of loneliness.

The contradictions between the opinionnaire sorting of feelings of loneliness and verbal expressions of loneliness were indicative of the ambivalence encountered in loneliness. Ambivalence between expressing feelings of loneliness and denying the feelings of loneliness.

CHAPTER V
SUMMARY, CONCLUSIONS,
IMPLICATIONS FOR NURSING
RECOMMENDATIONS

SUMMARY

The purposes of this study were: 1) to evaluate nursing staffing policies in five general hospitals to determine if these hospitals provide for continuity of contact between nurses and patients; 2) to determine if medical-surgical patients in five general hospitals experience feelings of loneliness while hospitalized; 3) to determine if patients are able to identify consistency and continuity of contact by nurses; 4) to determine if patients are able to identify and express their feelings about loneliness during hospitalization; 5) to identify those instances in which patient loneliness occurs even in the presence of continuity of hospital staffing; and 6) to determine from these findings implications for nurses directed toward improved, quality nursing care services for the hospitalized patient. The problem of this study was to determine the relationship between continuity of contact by nursing personnel and feelings of loneliness and alienation in the hospitalized patient.

The study was conducted in five general hospitals in Montana. The sample population was derived from a modified selected sampling procedure. Sixty-four patients from the five hospitals constitute the sample. Patients were tested on a total of seventeen medical and surgical wards of the five hospitals. Permission was granted by the Directors of Nursing in the five hospitals to conduct the study.

The method of collecting the data was by means of patients' opinions about nursing care, continuity of contact by nurses, hospital environment and loneliness while hospitalized. A Patient Opinionnaire was developed as the testing instrument. The opinionnaire was patterned after the Q-sort technique, but was not a true example of Q-methodology.

Statements about nurse-patient interpersonal relationships and factors of hospitalization leading to patient loneliness were derived from the literature. Each statement from the literature was divided into a pair of statements; one statement written to represent the Ideal hospital situation, and the other to represent the Actual hospital situation for the patient. The two categories were labeled the Ideal and the Actual. Each

statement was typed on a separate card. Each category contained twenty-nine statements. Patients were asked to sort the cards according to a continuum of how often the situation presented on each card occurred for the patient. The continuum sorting categories ranged from 1-5 and were labeled 1) Never, 2) Rarely, 3) At Times, 4) Often, and 5) Always. Patients sorted one deck of cards at a time; first the Ideal set and then the Actual. A follow-up interview was conducted after the cards were sorted which asked the patient for verbal responses to questions about their feelings of loneliness while hospitalized.

A pilot testing of the instrument was conducted on five patients at one of the hospitals included in the study. The five patients of the pilot study were included in the total sample of sixty-four patients.

A questionnaire was also developed and administered to head nurses and charge nurses on the particular wards where patients were tested. The questionnaire was given to determine staffing policies on those wards. Questions were asked about the particular approach to nursing care in operation on each of the wards, if the ward had a regular or steady nursing staff, the use of float nurses on

the ward, and the frequency that nurses were rotated from position to position, or from team to team on the ward. The nurses were also asked, in their opinion, if patients received continuity of nursing contact.

Patient loneliness, in this study, was theorized to occur when a discrepancy existed between the patients' Ideal opinion of hospitalization and his Actual hospital experience. A discrepancy score for each pair of statements was obtained by subtracting the number on the continuum category where the actual card was placed from the number on the continuum category where the ideal statement was placed. The discrepancy scores, twenty-nine for each patient, were coded, keypunched, and submitted to the computer to obtain the Mean Discrepancy Score for each of the twenty-nine items.

The Mean Discrepancy Scores represented the analysis of data for the study. In addition, verbatim responses of patients to the follow-up questions were compared to the results of the analysis of data. The nurses responses on the questionnaires were examined for their opinions of nurse-patient continuity of contact in relationship to the results obtained from patients' opinions.

The Mean Discrepancy Scores were depicted in a table in order of magnitude to demonstrate which items showed the greatest discrepancy from a "perfect score". For all but three items (22, 23, and 25), a "perfect score" was 0 (zero). A "perfect score" signified there was no difference between patients' Ideal conception of hospitalization and Actual hospital treatment. Items which showed a Mean Discrepancy Score from 0 to ± 0.5 were not considered significant in demonstrating lack of continuity of contact or loneliness.

CONCLUSIONS

As a result of the analysis of the Mean Discrepancy Scores of the twenty-nine items, the investigator made the following conclusions according to the purposes of the study:

1. To evaluate nursing staffing policies in five general hospitals to determine if these hospitals provide for continuity of contact between nurses and patients.

The method of evaluating staffing for continuity of contact was by means of obtaining opinions of charge nurses and head nurses in this area.

All nurses, but one, completing the questionnaire replied that continuity of contact was provided for patients. It was concluded, then, for purposes of analysis, that continuity of contact was in existence on sixteen of the seventeen wards of the five hospitals.

The analysis of the questionnaire and patient opinionnaires from the one ward where the nurse replied continuity of contact was not in existence, showed patient loneliness for the two patients tested there.

The investigator concluded that although nurses stated, in their opinion, that continuity of contact was provided, their responses to the use of float nurses indicated a frequency in the assignment of float nurses to these wards. The majority (6 of 11) of wards using the team approach to nursing care, rotated nurses from team to team every 1-2 weeks, indicating frequent rotation of nurses. It was further concluded by the investigator that nurses, although they stated continuity of contact was provided, are apparently not aware of, or do not recognize where gaps in continuity of contact occurs.

The investigator recognizes, however, that because of nurses' days off and other absences, 100% continuity cannot be realized.

2. To determine if medical-surgical patients in five general hospitals experience feelings of loneliness while hospitalized.

The analysis of Mean Discrepancy Scores on items of the Patient Opinionnaire revealed significant findings about patient loneliness. The Mean Discrepancy Scores of items 8, 9, 12, and 19 of the opinionnaire showed significance by being above the +0.5 level of significance for Mean Discrepancy Scores.

These items had Mean Discrepancy Scores which ranged from +0.7-+1.5. The conclusions for these items were that patients experienced loneliness because plans for the patients' future or home care were not discussed with the patient by nurses, nor were procedures of patients' care explained to patients so they were understood. Loneliness was present because patients did not know who the nurse on duty would be from day to day. It was further concluded that the greatest area of patient loneliness was experienced, according to opinionnaire analysis, due to the fact that patients did not have the meanings of tests, procedures, and examinations explained to them.

The Mean Discrepancy Score for item 10 of the opinionnaire was computed as -0.6. A Mean Discrepancy Score

which differed negatively from 0. revealed that the actual statement was placed higher in the continuum categories than the ideal statement. The conclusion for item 10, was that patients did not talk or express themselves as often as nurses were available to listen. On the basis of findings already cited from the literature, loneliness was present in this situation because patients were silent and did not express themselves.

The conclusion was reached that patients experienced loneliness due to the variety and frequency of nurses taking care of them. Item 15, relating to this area, was significant with a Mean Discrepancy Score of -0.8. The score of -0.8 indicated that there was a variety of nurses and personnel caring for patients which the patients, ideally, did not like. Item 15 is especially significant in that it was classified in the area of continuity of contact when statements were divided into areas relating to nurse-patient interaction. The conclusion, from this statement, is that there is a relationship between continuity of contact by nurses and loneliness of the patient.

Further conclusions that patients do experience loneliness in the hospital were reached on the basis of patient responses to the opinionnaire follow-up questions.

The verbatim responses of patients will be discussed in the fourth purpose of the study.

The fact that two patients in the sample, who were hospitalized on the ward which reported continuity of contact was not provided, demonstrated loneliness by means of the Patient Opinionnaire and verbal response to the follow-up questions was concluded to mean that patients do experience feelings of loneliness and also that there is a relationship between continuity of contact by nurses and patient loneliness.

3. To determine if patients are able to identify consistency and continuity of contact by nurses.

Statements written for the opinionnaire were classified into five broad areas of nurse-patient interaction and features of total nursing care. The statements classified into the area relating to continuity of contact were numbers 12, 13, 15, 17, 28, and 29.

The statements which showed significance according to the Mean Discrepancy Scores were statements 12, 15, and 28. Statement 29 showed a Mean Discrepancy Score of +0.5, which was just at the set level beyond which significance occurred. The conclusion was, then three of the six

statements showed significance and one statement was just at the level of significance, and that patients were, therefore, able to identify consistency and continuity (or lack of) by nurses.

The investigator concluded from these statements that patients wanted more opportunity to talk with nurses and that patients desire continuity in the contact they receive from nurses. Continuity of contact in the nurse-patient relationship is the beginning of providing the patient with an atmosphere in which he can be comfortable while hospitalized.

4. To determine if patients are able to identify and express their feelings about loneliness during hospitalization.

Conclusions were presented for Purpose 2 of the study that patients expressed loneliness in certain areas by means of the opinionnaire. The responses obtained from the follow-up questions asked after patients completed the opinionnaire, presented further conclusions that patients do experience loneliness while hospitalized.

Non-verbal behavior of the patients, when questioned about loneliness, indicated that this was an uncomfortable and difficult subject to discuss. Patients, in

many instances, replied "no" to the question and after that added reasons for not being lonely, or would then talk about loneliness. Patients said they were not lonely because of visitations from family and friends, because they had a roommate to talk to, because they could get up and go talk to other people, or because they had a television to watch. Thirty patients gave reasons for not being lonely which did not mention hospital or nursing personnel as a factor in not being lonely.

Five patients replied that they were not lonely because they spent much of their time, ordinarily, alone, and were accustomed to being alone and not being lonely.

Ten patients replied that they were not lonely because of the presence and friendliness of nurses and hospital personnel. One patient answered the question with: "I don't think you'd ever get lonely in a hospital because of all the people."

Nine patients replied "no" to the question at first, and then went on to talk about loneliness, in some cases referring loneliness to a third person.

Ten patients replied "yes" to the question and these patients discussed interpersonal relationships with nurses as a factor in the loneliness experienced in the hospital.

One patient who was interviewed replied: "No. I just have the blahs today." After that response, the patient began to cry and gave the following response:

I thought I was going home today. You ask the nurses a question about pills or anything and they just ignore you. A couple of nurses are good, but most of them don't bother to visit patients or get to know their patients. I had company today. Now I'm alone. I wanted to go home.

It was concluded that this study showed that loneliness does exist in the five hospitals and that patients, in many cases, were able to express themselves about loneliness; although it is a difficult and uncomfortable subject for them.

Appendix H contains a more complete presentation of patients' verbatim responses to the question of loneliness.

5. To identify those instances in which patient loneliness occurs even in the presence of continuity of hospital staffing.

The conclusion derived from nurses' responses on the questionnaire was that patients were provided continuity of contact by nurses.

The conclusions that patients experience loneliness were stated in discussions of the previous purposes.

The responses of patients who described loneliness while hospitalized indicated dissatisfaction with nurse-patient relationships and spoke of areas of impersonalization of nurses.

The conclusion, then, was that loneliness was present for patients in the five hospitals, despite the fact that continuity of contact was provided by nurses. The factors patients spoke of which contributed to hospital loneliness were those concerned with interpersonal relationships and nurse-patient interaction.

The hypothesis for the study was stated as:

There is no relationship between continuity of contact by nurses and loneliness experienced by the hospitalized patient.

On the basis of the conclusions which have been stated, the hypothesis for this study was rejected. Loneliness did exist for patients in the five hospitals although nurses attested to continuity of contact. It was also concluded that loneliness was present for patients in the five hospitals in instances where patients, by means of the

opinionnaire, replied that many personnel took care of them and that they did not know who the nurse on duty would be from day to day.

Marie Manthey contributes to the rejection of the study's hypothesis by stating:

It has been said that the quantity of contact between patient and nurse is not what is important, but rather the quality of contact. The necessary ingredient of quality is propinquity.⁶¹

The investigator concluded that the crucial factor in the relationship between continuity of contact by nurse and patient loneliness was the quality of the nurse-patient relationship. Continuity of contact alone does not imply that because there is continuity of contact or that because a nurse is available she will listen or become involved with the patient's feelings of loneliness.

Implications For Nursing

The last purpose of this study was to determine from the findings of the study implications for nurses directed toward improved, quality nursing care services for hospitalized patients.

⁶¹Marie Manthey, "A Dialogue on Primary Nursing", Nursing Forum, Vol. IX, No. 4, (1970), p. 373.

The conclusions reached in the study were that hospitalized patients do experience feelings of loneliness, that there is a relationship between the contact the patient receives from nurses and the loneliness the patient experiences, and that the quality of contact between nurses and patients was the crucial aspect of patients' hospital experiences.

From the investigator's personal experience in researching and writing on the theme of loneliness, from interviews with hospitalized patients, and from the findings of the study, certain implications for nurses and nursing practice became evident.

The prerequisite for becoming aware of and avoiding loneliness is the establishment of meaningful relationships. Establishing meaningful relationships is dependent on a willingness to communicate on a two-way basis with our fellowmen.

If nursing is to be a caring, helping profession, nurses must become involved with more than physical aspects of nursing care. They must become involved with the total person that is the patient, and realize the patient needs more than clean, sanitary surroundings, medications and rest.

To practice involvement, it is necessary for the

nurse to become aware of her own experiences and feelings. Nurses must be willing to accept their own humanness and become aware of, and accept their own feelings of fear, anxiety, anger and loneliness before they can fully recognize and understand these feelings in patients. When the nurse is aware of, and accepting of herself, she communicates herself to the patient and the patient then is freed to be himself and communicate himself in return.

Nurses need to create an atmosphere in which the patient feels free to express his feelings. Nurses can learn to create a therapeutic atmosphere by actively seeking to understand and by helping patients become aware of and understand his own feelings. If the nurse is hearing only the patients' words, then the patient may feel frustrated and lonely. Nurses must work to identify feelings, so the patient feels understood. In order to really understand the patient's experiences and feelings, nurses must learn to listen, not to reply.

The nurse-patient, relationship should be a therapeutic part of the patient's hospitalization. Relationships must be established which offer enough security for the patient to express himself and lower his defenses. Therapeutic nurse-patient relationships can be provided only if

nurses learn to convey the attitude of willingness to become openly involved with patients as human beings.

If nurses learn to provide a climate which is secure, a climate conducive to self-disclosure, and a climate in which both the patient and the nurse are actively involved, then nurses can prevent feelings of loneliness from becoming painful and frustrating to the patient. Nurses can also help to relieve feelings of loneliness that have reached painful degrees.

An implication which became evident during the administration of the opinionnaire was that nurses must learn to communicate their role to patients. Many patients commented that perhaps some of the statements on the opinionnaire cards were not the nurses' duty.

The foregoing implications become apparent as implications for nursing education. Aspects of loneliness and involvement in nurse-patient relationships must become a part of nursing education. Nursing instructors can help students gain awareness and insight by sharing their own experiences with students. Nursing textbooks need to incorporate aspects of loneliness into their framework for nursing.

The conclusion for these implications is that:

Sincere attempts to know and to understand a patient and to help him be comfortable, increase his sense of identity and integrity, and this experience seemsto be a factor in healing.⁶²

The topic of loneliness seemed to be such a painful and frightening one that patients in this study, when talking of and expressing loneliness, seemed to avoid or deny the depth of feeling encountered with loneliness. They expressed loneliness in general terms.

This study merely touched the surface in attempting to describe the loneliness of hospitalized patients. It was, however, a beginning towards defining the problem area of loneliness as requiring a framework of nursing intervention.

Recommendations

After reviewing the findings of the study, the investigator believes there are several recommendations for further study:

1. The same study could be replicated through the use of a larger sample, and fewer delimitations.

2. A similar study could be conducted at hospitals which have been designed for closer nurse-patient contact;

⁶²Sidney M. Jourard, The Transparent Self, p. 206.

for example, the circular concept of hospital design.

3. That a tool be developed and standardized for further studies into loneliness.

4. A similar study using a more standardized testing procedure.

5. A similar study using interviews and/or a standardized testing method about loneliness using nurses as the sample population and comparing nurses' perceptions of loneliness and patient loneliness with patients' responses.

6. Patients in this study demonstrated much reluctance to express criticism toward nurses while hospitalized. Reluctance was present despite assuring patients of their anonymity and the fact that nurses would not have access to or know of their responses and that no nurse would be singled out as a result of patient criticism.

An experimental approach to the problem of loneliness of hospitalized patients could be conducted using a sample of hospitalized patients and a sample of people who had been hospitalized and would be away from the hospital environment during the time of testing.

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APPENDIX

APPENDIX A

INSTRUCTIONS FOR COMPLETION OF OPINIONNAIRE

Almost everyone has an opinion as to how nurses should act toward patients. As a patient, you have been able to observe how nurses relate to patients.

You are being asked to give your opinion and express your feelings about your experiences while in the hospital. The cards you are being asked to sort are concerned with interactions between nurses and patients. Only from opinions of patients can we learn ways of giving better service and quality nursing care to patients.

Please feel free to be honest and open in expressing your opinions. Your name will not be used in the study and your opinions will remain anonymous. Nurses and nursing staff will not have access to your answers on the opinionnaire.

The study is not meant to be highly critical of nurses, but to help nurses find ways of improving nursing care and nurse-patient relationships.

The term NURSE in this testing instrument will ALWAYS refer to the REGISTERED NURSE --- the R. N.

There are five (5) categories for sorting the cards. The PATIENT OPINIONNAIRE GUIDE will help you sort

the cards. There are two (2) sets of cards (29 cards in each set) which describe hospitalization and nurse-patient interactions. Please read the statements carefully. You will be given a set of cards to sort, one set at a time. The first set of cards describes how you LIKE things in the hospital --- the IDEAL. The second set of cards describes how the hospital REALLY IS for you --- the ACTUAL

Thank you very much for your valuable help in contributing to this study.

APPENDIX B

PATIENT OPINIONNAIRE STATEMENTS

<u>IDEAL</u>	<u>ACTUAL</u>
1. I like my family to visit me.	1. My family visits me.
2. I like my friends to visit me.	2. My friends visit me.
3. I like to watch TV alone.	3. I watch TV alone.
4. I like to think alone.	4. I spend time thinking alone.
5. I like to sleep a great deal.	5. I am able to sleep when I want.
6. I like being "left alone" and undisturbed by nurses.	6. I am left alone and undisturbed by nurses.
7. I like the nurses to spend time just talking to me.	7. The nurses spend time just talking to me.
8. I like the nurses to explain procedures of my care to me so I understand them.	8. The nurses explain procedures of my care to me so I understand.
9. I like the nurses to discuss plans for my future (or home) care with me.	9. The nurses discuss plans for my future (or home) care with me.
10. I like the nurses to take time to <u>listen</u> to me, when I feel like talking.	10. The nurses take time to <u>listen</u> to me when I express my feelings.
11. I like to know the nurse is interested and sympathetic to me as a <u>person</u> .	11. I know the nurse is interested and sympathetic to me as a <u>person</u> .
12. I like to know who the nurse on duty will be from day to day.	12. I know who the nurse on duty will be from day to day.
13. I like having someone to call "My Nurse."	13. There is an R.N. on this ward I can call "My Nurse."
14. I like many hospital personnel to visit my room.	14. Many different hospital personnel visit my room.
15. I like a variety of nurses to take care of me -- for instance, a different nurse each day.	15. There are a variety of nurses and personnel on this ward -- perhaps a different nurse each day.
16. I like the nurses to encourage me to talk and express my feelings.	16. The nurses encourage me to talk and express my feelings.

IDEAL

17. I like to see the nurse on duty and to know she is close-by if I need her.
18. I like to believe the nurses can accept, understand, and care for me as a person.
19. I like to know the meaning of the tests, examinations, and procedures that are given to me.
20. I like to believe I still have my independence as a person while I am a patient.
21. I like the nurse to recognize me as a person, not just an illness.
22. I like being informed about my illness and the meaning of things that are done to me.
23. I like having something to do to help pass the time while in the hospital.
24. I like to believe the hospital is a warm, personal environment.
25. I like many different hospital personnel coming and going in my room so I will not feel lonely.
26. I would like the nurse to be my friend -- with whom I can share my thoughts and feelings.
27. I like to be able to tell someone what is really on my mind.

ACTUAL

17. I know the nurse is closeby if I need her because she tells me so when she comes to see me.
18. I believe the nurses accept, understand, and care for me as a person.
19. The nurses explain the meaning of the tests, examinations, and procedures that are given to me.
20. As a patient, I still have my independence as a person.
21. The nurses treat me as a person, not just an illness.
22. I feel lost because I have a minimum of information about my illness and the meaning of things that are done to me.
23. I feel bored because I am left to pass the time in whatever way I can.
24. The hospital environment is warm and personal.
25. I am lonely even though many hospital personnel and people are coming and going in my room.
26. There is one nurse who is like a friend with whom I can share my thoughts and feelings.
27. I am able to tell the nurse what is really on my mind.

IDEAL

ACTUAL

- | | |
|--|---|
| 28. I like to know when one nurse will be leaving for the day and another will take her place. | 28. I know when the nurse leaves for the day and another one takes her place. |
| 29. I would like the same nurses to take care of me every day. | 29. The same nurses take care of me every day. |

APPENDIX C

SAMPLE OF PATIENT OPINIONNAIRE GUIDE

1.

NEVER

(not at all,
not ever)

2.

RARELY

(seldom,
infrequently)

3.

AT TIMES

(sometimes,
occasionally)

4.

OFTEN

(frequently,
many times)

5.

ALWAYS

(a lot,
at all times)

APPENDIX D

PATIENT OPINIONNAIRE TABULATION, AND DATA SHEETS

AND VERBATIM RESPONSE TO OPINIONNAIRE FOLLOW-UP QUESTIONS

TABULATION SHEET:

I. IDEAL: Cards sorted as follows--

1.
NEVER

2.
RARELY

3.
AT TIMES

4.
OFTEN

5.
ALWAYS

-105-

II. ACTUAL: Cards sorted as follows--

1.
NEVER

2.
RARELY

3.
AT TIMES

4.
OFTEN

5.
ALWAYS

PATIENT DATA SHEET:

PATIENT # _____ HOSPITAL CODE _____
MALE _____ FEMALE _____ WARD _____
AGE _____ DIAGNOSIS _____
HOSPITAL DAY # _____

VERBATIM RESPONSE TO OPINIONNAIRE FOLLOW-UP QUESTIONS:

1. Have you felt lonely while in the hospital?
2. If so, can you name (specify) a cause for your loneliness in the hospital?
3. Is this your first time in the hospital?

APPENDIX E

QUESTIONNAIRE FOR TYPE OF NURSING CARE/STAFFING POLICIES

Please circle your response to each question appropriate for this ward, and answer questions briefly. Thank you for your cooperation.

1. What approach to Nursing Care is in operation on this ward?

- A. Functional Nursing B. Team Nursing
C. Other (Specify)

2. Do you have a "steady" or regular staff of Registered Nurses assigned to this ward?

- A. Yes B. No

3. Is this ward staffed by "float" nurses (Registered Nurses)?

- A. Yes B. No

4. If "float" nurses (Registered Nurses) are employed on this ward, how often?

5. If Team Nursing is in operation on this ward, are Registered Nurses rotated or switched from team to team?

- A. Yes B. No

If "Yes" --- how often? (every week? every two weeks? 6 weeks?)

6. If Functional Nursing is in operation on this ward, are the Registered Nurses rotated from position to position?
- A. Yes B. No

If "Yes" --- how often?

7. In your opinion, do patients on this ward receive continuity of contact from the nursing staff (Registered Nurses)?

(CONTINUITY of NURSING CONTACT --- nursing care given to a patient by the same nurse on two or more consecutive days. The term "care" is taken to include responsibility for the patient and/or patient care needs, nurse-patient interactions, and direct nursing care.)

- A. Yes B. No

APPENDIX F

SAMPLE OF LETTER SENT TO DIRECTOR OF NURSING FOR PILOT STUDY

Bozeman, Montana 59715
January 21, 1974

Director of Nursing Service
Hospital
Montana

Dear _____:

As a graduate student of the School of Nursing at Montana State University, I am required to explore an area of current interest to me in a research thesis. My particular experience in nursing has led me to believe that patients experience loneliness during hospitalization. It is my desire to approach the problem of loneliness as it relates to continuity of contact by hospital personnel with patients. I am particularly interested in continuity of contact by nurses with patients.

I am in the process of developing a Q-sort opinionnaire for patient testing to be used in evaluating loneliness in the hospitalized patient. I am planning to test adult patients who are involved in active treatment. Patients in Isolation and critically ill patients will not be tested. The Q-sort will be simple and easily completed by the patients.

I am hoping to test a random sampling of patients from five hospitals in Montana. At present I am awaiting permission to test patients involved in active treatment in other hospitals. In the meantime, I would like permission to do a pilot study at your hospital. The pilot study is necessary to test and validate the testing instrument. The same random sampling procedure for selection of patients will be used as will be used at the other four hospitals. The data obtained in the pilot study will then be included in the thesis.

I have not set specific dates yet for my testing, but, awaiting your approval, I will set tentative dates to do my research.

Your cooperation in allowing me to test patients admitted to your hospital in the pilot study will be greatly appreciated. If you have further questions regarding this matter, please let me know.

Thank you for your consideration in this matter. I will anticipate your reply.

Respectfully yours,

Marlene E. Tracy, R. N.

Marlene Tracy is a graduate student at Montana State University School of Nursing. The School of Nursing would appreciate your cooperation in allowing her to test patients admitted to your hospital.

Laura Walker, R. N. PH.D.
Director, School of Nursing

APPENDIX G

SAMPLE OF LETTER SENT TO DIRECTORS OF NURSING

Bozeman, Montana 59715
January 16, 1974

Director of Nursing Service
Hospital
Montana

Dear _____:

As a graduate student of the School of Nursing at Montana State University, I am required to explore an area of current interest to me in a research thesis. My particular experience in nursing has led me to believe that patients experience loneliness during hospitalization. It is my desire to approach the problem of loneliness as it relates to continuity of contact by hospital personnel with patients. I am particularly interested in continuity of contact by nurses with patients. I am in the process of developing a Q-sort opinionnaire for patient testing to be used in evaluating loneliness in the hospitalized patient. I am planning to test adult patients who are involved in active treatment. Patients in Isolation and critically ill patients will not be tested. The Q-sort will be simple and easily completed by the patients.

I have not set specific dates yet for my testing, but, awaiting your approval, I will set tentative dates to do my research.

Your cooperation in allowing me to test patients admitted to your hospital from a random sampling procedure would be greatly appreciated. If you have further questions regarding this matter, please let me know.

Thank you for your consideration in this matter and I will anticipate your reply.

Respectfully yours,

Marlene E. Tracy, R. N.

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Marlene Tracy is a graduate student at Montana State University School of Nursing. The School of Nursing would appreciate your cooperation in allowing her to test patients admitted to your hospital.

Mrs. Laura Walker, R. N., Ph. D.
Director, School of Nursing

APPENDIX H

VERBATIM RESPONSES OF PATIENTS TO QUESTION OF LONELINESS IN HOSPITAL

I'll make it. Hospitals can be lonesome unless you have someone to visit you.

No, not really. But this hospital is lonesome because there's no phones in the rooms. That phone makes a lot of difference.

No, but there's nothing to do. If there was something to do, it would be better.

Not as long as I have a roommate. The hospital can be a lonesome place if you don't have someone to talk to.

Oh, no, not really. I had a couple of good bawls -- but that wasn't because of loneliness, it was because I was so scared.

#No. Well, I've been an outdoors person and I've never been sick much. I get tired sitting here. I don't like the confinement. I guess you would call that loneliness.

#Just one day --- one afternoon. Because there were so few patients here and it was so quiet. Like no one was around.

Yes, I was for a few days. Then I got a TV. The TV has really helped.

Yes, definitely. Because I've been here too long.

Yes. I realize the nurses are busy, but they should have more help, then. You don't get any attention unless you ask for something. They just ignore you around here. If you ask for something or something for pain, they're too busy with paper work. Here I am in a ward full of people. All these nurses in here and the ones coming and going --- I don't know them.

We all have those days, I suppose. You can feel lonely wherever you're at sometimes.

Yes, at times. I really miss my husband and three young children.

Yes. Only at times though. Mostly at night.

Yes. I wish to be outside. I am lonely because of being in the hospital and being bedridden. Also, I don't have many people to visit me.

Yes. I miss my baby at home. A couple of nurses are good. But a couple have been deliberately mean.

In the evenings it gets lonely. I don't like TV and I just wish there was something to do. There aren't

enough nurses on duty to be able to visit everyone or visit a lot. But there's a lot of people who don't have company and could use someone to talk to. I'd like to be able to get up and go talk to everyone.

No, not really. But that's because of my family. They come often and I know when they are coming. About the nurses, though, I think people have changed. I don't think a lot of the nurses really care about people much any more --- or don't show that they do. The nurses give good care but they don't seem to really care or have compassion for people. I guess what it comes down to any more is a job is a job. It's the paycheck that is important. That's why I think there is a lot of loneliness in the hospital.

Well, some nurses are really good -- they come by and talk to you and ask a few personal questions and it draws you out and you feel better. Some nurses express themselves real good. There are some nurses I couldn't, I wouldn't be able to ask for things from. I think there is a lot of loneliness in the hospital. But for me, I just want to feel better and go home.

#No, I just have the blahs today. I thought I was going home today. You ask the nurses a question about pills or anything and they just ignore you. A couple nurses

are good, but most of them don't bother to visit patients or get to know their patients. I had company today. Now I'm alone. I wanted to go home. (Patient was crying during the interview.)

No. As a person, I like to spend time alone. I spend a lot of time alone without being lonely.

No. I'm not a lonely person. I'm a widow and spend time alone. Loneliness never has bothered me.

No. I'm not a basically lonely man outside the hospital so I'm not that way as a patient.

No. I'm not a person who gets lonely. I like spending time alone.

The hospital environment lends itself to loneliness. It's not the same as being out and on the job, or other things. People in the hospital spend a lot of time alone. They have a lot of time alone to think. As for me, I do not feel lonely. I'm kind of a loner, I live alone, I like to backpack up in the hills and get away from people. So I'm not bothered by loneliness here.

No, I've never been lonely in my life. Except one time when I was in the service and was in London. The biggest city in the world and I didn't know a soul.

No, not really. I have a good roommate and I get up and walk and talk to other people. I spent a couple

of days in the Intensive Care Unit. I was really scared there.

No, but if I'm in here much longer, I will be.

No, I do OK, even if I'm by myself.

No, but I don't like hospitals anyway.

Not so far, I've had lots of company.

No, not today. I would have been if my friends hadn't shown up today.

No, because I don't watch much TV at home. So being in the hospital, I enjoy watching it.

No. I've been here so many times, I know everyone. This hospital is more personal and friendly than others I've been in.

No. The people are friendly and they come to see you a lot. I don't think you'd ever get lonely in a hospital because of all the people.

Oh, no, I never get lonely here. The hospital might be a lonesome place for some people, but not for me.

Further replies to the question of loneliness were "no" or "never" responses and many patients replied they were not lonely in the hospital because of friends, family, because of sleeping a lot and because of roommates. Some patients replied they were not lonely because of all the

people coming and going and because the nurses were friendly and gave good care. However, the number of patients who replied they were not lonely because of nurses and nursing personnel was a small minority (10).

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