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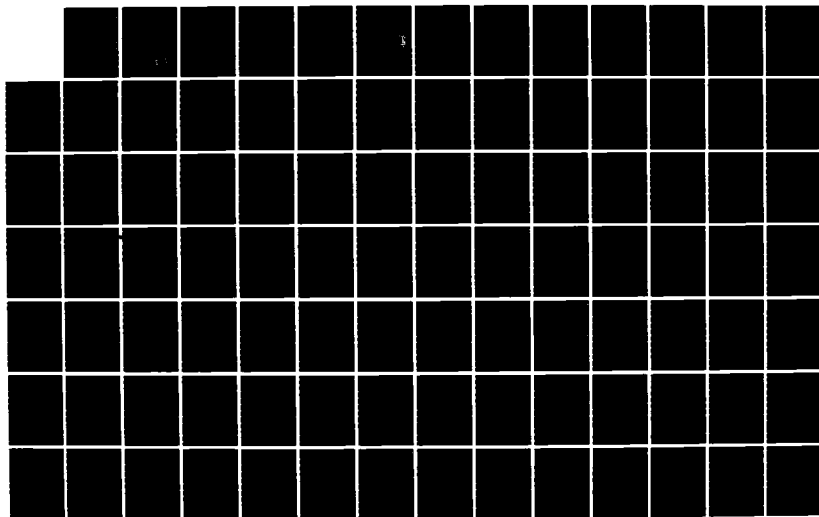
AN EXPLORATORY STUDY OF ALIENATION IN HOSPITALIZED AND  
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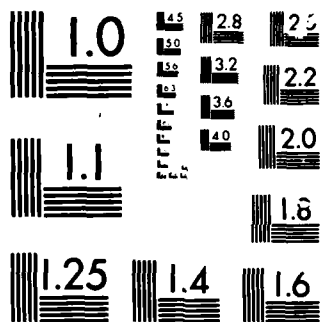
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## ABSTRACT

↖ This study examined the responses of 64 subjects to two subscales of the Belcher Extended Loneliness Scale (Belcher, 1973) that measured both internal and external aspects of alienation. Four equal groups of subjects were selected: hospitalized with cancer; nonhospitalized with cancer; hospitalized without cancer; nonhospitalized without cancer. The purpose was to study differences and patterns in the alienation scores reported by subjects in the four groups. The secondary goal was to explore the potential that the analysis of the concept of alienation has for improving the care of clients with cancer.

Seven hypotheses were proposed. The first three hypotheses proposed that subjects who have cancer will report higher scores on three separate measures of alienation (external, internal and a combined score of the two measures) than subjects without cancer. The next three hypotheses proposed that subjects who are hospitalized will report higher scores on three separate measures of alienation (external, internal, and a combined score of the two measures) than subjects not hospitalized. The seventh hypothesis proposed a difference among the four groups of subjects based on their total (external plus internal) scores.

The first six hypotheses were supported by mean scores for external, internal, and combined scores. The seventh hypothesis failed to be supported at  $p < 0.05$  for a two-factor analysis of

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variance for the total (external plus internal) scores and the variables of cancer and hospitalization. A correlation coefficient was done and it was found that clients who were active in organizations had significantly lower alienation scores ( $p < 0.05$ ) than those not active in organizations.

Recommendations for future studies include: choosing subjects at larger USAF hospitals with inpatient cancer units and facilities for radiation therapy; increasing the size of the sample in each group; controlling for diagnostic category; matching samples based on sex, diagnosis, and stage of disease; collecting information on the composition and activity of clients' support groups, diagnosis, stage of disease, and treatment; studying clients in the aeromedical evacuation system; conducting longitudinal studies of clients so that alienation pre and post diagnosis scores can be compared.

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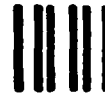
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**An Exploratory Study of Alienation in Hospitalized and  
Nonhospitalized Clients With and Without Cancer**

**Ronald E. Rydgren**

**A Thesis Submitted in Partial  
Fulfillment of the Requirements  
for the Master of Science in Nursing**

**School of Nursing  
Southern Illinois University  
Edwardsville, Illinois**

**March, 1986**

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## CHAPTER ONE

When viewed retrospectively, the investigator's interest in the concept of alienation began when as a young Marine Corps infantryman he served 13 months in Viet Nam. While there he saw people "alienated" from one another to the extent that they readily took human life -- North Vietnamese, South Vietnamese, and Americans alike. It is very probable that part of the investigator's desire to help people and his eventual entrance into the profession of nursing was influenced by the tragedy that he saw and experienced while in Southeast Asia.

First, as a student of psychology, and later, as a student of nursing, the investigator had a particular interest in the subject of "death and dying". As a practicing registered nurse, he gravitated toward working with clients who were dying. He strongly believed that improving the quality of life for those who were labeled as dying was of the utmost importance. As an officer in the United States Air Force Nurse Corps, the investigator worked as a team leader in an Intensive Care Unit and as a volunteer, and later as chairperson, of an Air Force Medical Center's Maximum Living Potential Team. Many of the clients that the investigator worked with had cancer and he developed an interest in what he would later come to call their alienation.

The investigator also gained a personal perspective on alienation when his wife was diagnosed with cancer shortly before their marriage in 1981. During many hours spent in the waiting

rooms of medical units, diagnostic areas, surgical units, cancer units, and radiation therapy areas, he had the opportunity to observe, talk with, listen to, and learn from many clients with cancer and from those important to them. In addition to the investigator's desire to study alienation, there is a great deal of evidence in the literature that points to the need for a better understanding of this concept.

It is well documented that cancer is a devastating and frightening disease that tends to disrupt normal patterns of relating to others and to one's self. Mastrovito (1974) stated that cancer is dreaded and feared because it implies a fatal outcome, pain, body damage, and deterioration. Abrams and Finesinger (1953) and Creech (1975) noted that clients with cancer often perceived themselves to be dirty, decaying, unclean, and suffer guilt and shame because they had cancer.

Bahnson (1975) described the extremely negative connotations and social unacceptability of cancer as compared to other life-threatening diseases and observed the isolation and avoidance of clients with cancer by other people. These people tended to withdraw and invest their energies in other relationships where they felt there was more reciprocity -- clients with cancer were considered by others to be a poor investment both socially and economically. Freidenbergs, Gordon, Hibbard, & Diller (1980) discussed the great amount of psychosocial distress experienced by

persons diagnosed with cancer, and the difficult task that health care providers face in assessing and reducing such distress.

Many psychosocial reactions adversely affect the cancer patient's quality of life. Many health care professionals believe that length of survival may be affected by these psychosocial factors (Burns, 1982). Craig and Abeloff (1974) proposed that the disease process may be greatly affected by emotional factors in some subgroups of those who have cancer, while in other subgroups there may be no effect.

Among the factors that may influence quality of life and longevity is alienation. Weisman and Worden (1975) found that longevity in clients with cancer was significantly related to active and mutually responsive relationships with others; shorter survival times were found in those clients who were alienated in personal life and from those providing their care. In considering the above study Kastenbaum (1977) stated that, regardless of the type of life-threatening illness, the person who becomes alienated is at increased risk as compared to those who maintain close relationships with others. In addition to poorer prospects for survival Seeman (1971) found, in several studies, that the condition of being alienated was associated with a poorer knowledge base than patients not alienated. In one such study, Seeman found that tuberculosis patients on 35 wards in 10 Ohio hospitals showed significantly poorer knowledge about their condition, treatment, and general health matters than those who were not alienated.

In a thorough review of the literature the investigator could not find any clinical studies that specifically addressed the condition of alienation in clients with cancer. Three studies were found that dealt with two different variants of alienation -- social isolation and powerlessness. The First of these studies (McKeough, Edwards, Chamberlain, & Nogeire, 1980) examined social isolation in lung cancer patients and found that these clients were significantly more socially isolated than a control group of clients with chronic, obstructive pulmonary disease (COPD). It was noted that such isolation reduced the effectiveness of home health care and resulted in dangerous symptoms going unreported. The next two studies (Linn, & Linn, Harris, 1982; & Linn, & Linn, 1981) discussed the effects of counseling on late stage cancer patients. A test of social isolation and powerlessness was used as one of several tests to measure quality of life. It was found that compared to a control group, clients who had been receiving counseling were less alienated and more internally controlled than clients not receiving counseling.

Through examination of the literature and empirical study, the investigator intended to contribute to a better understanding of the concept of alienation, to suggest improvements in the nursing care of clients with cancer and the quality of life of clients who have cancer.

### Statement of the Problem

The problem considered was to determine if clients who have cancer score differently on a test of alienation than clients who do not have cancer.

A test of alienation was used to reveal differences among four groups of clients -- hospitalized with cancer; nonhospitalized with cancer; hospitalized without cancer; nonhospitalized without cancer

### Significance of the Problem

Cancer is a source of severe psychological and somatic stress that gives the client an overwhelming sense of helplessness (Mastrivito, 1974) and feelings of hopelessness about the future (Craig, & Abeloff, (1974). Beginning with the knowledge that one has cancer, there is an increased need for satisfying social relationships and information. However, clients with cancer often find their needs frustrated as they elicit signs of rejection, receive negative feedback over a long period of time, and encounter numerous barriers to communication. The ability of these clients to cope is directly related to their ability to maintain close personal relationships with family and friends (Wortman, & Dunkel-Schetter, 1979).

When the large number of people who suffer with and die from cancer each year is considered it is apparent that any insight into factors related to improvement in the quality of life will have an impact on a large number of clients and their families.

The American Cancer Society (1983) estimated that approximately 855,000 people would be diagnosed with cancer in 1983 and that about 440,000 people would die of the disease that year, i.e., approximately "1,205 people per day, about one every 72 seconds." (p.3).

The investigator reviewed a list of the titles of 2,217 dissertations and theses generated by University Microfilms International (1985) from a list of key words associated with alienation. He then classified them according to the discipline granting the degree, the year granted, and the type of degree. Although there were 610 scholarly works that included alienation in the title, not one study was found that was done within the discipline of nursing. The majority of these works were completed in Education, Language and Literature, Sociology, and General Psychology. Only nine studies were done in the Health Sciences and only eight in Clinical Psychology — none of the studies contained both the key words alienation and cancer.

#### Purpose of the Study

The purpose of this exploratory study was to determine differences and patterns in alienation scores reported by four groups of clients: hospitalized with cancer; nonhospitalized with cancer; hospitalized without cancer; nonhospitalized without cancer.

Additionally, this study of alienation was intended to increase understanding of the concept of alienation in hopes of

improving the care of clients with cancer. Johnson (1967) stated that the concept of alienation was far from being fully developed but that there was potential for practical utility that could be realized through the extensive work of nurses.

### Review of the Literature

This review of the literature will begin by putting the concept of alienation into perspective with a brief account of the development of the concept (how it has been operationalized) and an examination of problems associated with the concept. Secondly, the concept of alienation will be divided into two major perspectives that emerged in review of the literature, internal and external. On one hand alienation is viewed as it relates to an individuals' internal environment of thoughts, feelings, reactions, and so forth. And on the other hand alienation is viewed as it relates to external, social, and environmental factors. Third, some of the positive applications of the concept of alienation will be examined. Fourth, the concept of cancer will be related to alienation. And fifth the concept of stress is examined as it relates to both internal and external factors and their relationship to alienation.

### The Concept of Alienation

Alienation has been described in a great number of ways and the use of the term is prevalent in the literature. Johnson (1973) noted that the concept of alienation appears in theology, history,

philosophy, psychiatry, sociology, anthropology, education, economics, political science, and literature. Various authors have underscored the importance of alienation in terms of its impact on a relationship to human stress, suffering, longevity, learning, and communication.

### Alienation in Perspective

Among the earliest references to alienation were those found in religion and philosophy. Theologians referred to alienation as it concerned man's spiritual separation from God and from moral principles (Kuanungo, 1979). Alienation was mentioned as it pertained to man's separation from meaningful experiences with other men and institutions, nature and self (Johnson, 1973). Schacht (1970, p.XXV) noted that both Plato and Aristotle stated that "philosophy begins in wonder or perplexity." In Plato's Symposium, Aristophanes spoke symbolically of the alienation of man who, rather than being destroyed completely for his insolence to the gods, was split in two by Zeus. Since that time man had been looking for his other half, having an intense yearning to again become one with self (cited in Denise, 1973).

Two philosophers who are quoted by numerous authors when considering the modern uses of the concept of alienation are Hegel and Marx (Schacht, 1970; Bier, 1972; Murchland, 1971; Ollman, 1971; Schaff, 1980; Fromm, 1941 & 1955; Johnson, 1973, Seeman, 1959, and Kanungo, 1979). Hegel and Marx provide good examples of internal and external orientations to the concept of alienation

and will be discussed in their respective sections below. There are a great many differences evident among various conceptualizations of alienation and these differences lead to confusion and obfuscation of the concept.

The term alienation has been used by psychologists and sociologists to refer to various psychosocial disorders. Gerson (1965) stated that the terms anomie, anxiety, despair, depersonalization, apathy, loneliness, powerlessness, isolation, pessimism, and loss of self have been used to refer to describe the essence or characteristics of alienation. Numerous groups have been described as alienated due to their status in society: women; blue collar and white collar workers who find their jobs unfulfilling and degrading; juveniles; the old and lonely; blacks; societal nonconformists; migrant workers; immigrants; suicides; addicts; sex deviants; recluses; and others. Dean (1961, p. 753) found through a review of the literature that "apathy, authoritarianism, conformity, cynicism, hoboism, political hyperactivity, or personalization in politics, prejudice, privatization, psychosis, regression, and suicide" were correlates of alienation. Numerous studies have been conducted to clarify the concept of alienation and describe its importance.

Kanungo (1979) stated that there were five main areas in which the term "alienation" is used in a confusing way in the literature. For example, the term alienation has been used to refer to both groups and to the individuals, and, as Johnson (1973) stated, the meaning is different not only in the singular

versus plural sense but also qualitatively. Another area of confusion is a difference in how alienation is measured. In some literature, alienation is measured as the objective conditions that are observed by others and attributed to other groups, while in other sources, it is measured as the psychological state of the individual. A third area of concern is in the failure to differentiate between the conditions that cause alienation and the state of alienation that is caused by these conditions. Fourth, alienation is used to describe both cognitive and affective states of the individual. Fifth, alienation is viewed as being caused by historical events, such as early socialization, and also as being caused by recent events. Schacht (1970) stated that at present the term alienation can only function as a general term "denoting states of dissatisfaction, disharmony, and disaffection (p.195)" that involve or develop from one's feelings of being alien. Schacht suggested that efforts be made to clarify the meaning of the term. For the purpose of clarification and classification the following review will be divided into internally and externally-oriented references.

#### Internally-Oriented References

Hegel viewed alienation as a necessary part of man's spiritual development, a form of growing-up, and of distinguishing one's self from others. Alienation is viewed as standing back and objectively seeing one's self in order to be related to society. It is also seen as a pulling away from one's society in order to affirm one's self-identity. Willful assertion alienates self from

society, whereas passivity or surrender to society alienates one from the true self. Only in a blending of the two can there be harmony (cited in: Lauer, 1972; Kauffman, 1970; Schacht, 1970).

Among the beginning efforts to determine the empirical parameters of alienation was Davids' (1955) study of a group of 20 Harvard undergraduate students. He attempted to relate social perceptions to ego structure, and concluded that alienation was a syndrome composed of five interrelated dispositions -- egocentricity, distrust, pessimism, anxiety, and resentment.

Gould (1969) found that alienation had important psychological and sociological determinants. He studied alienation as it related to group conformity, from the point of view of the person experiencing it, and defined it as a syndrome made up of the feelings of pessimism, cynicism, distrust, apathy, and emotional distance. His findings suggested that first born or only children tended to be more alienated than later siblings, and that the alienated individuals tended to feel that it didn't matter what they did because they could not influence the outcome of events. It was also suggested that an alienated person may adopt a "front" or a pose of non-concern, and that in doing so, people use a process of defensive rationalization. Although he studied alienation from a psychodynamic perspective, Gould also noted that environmental influences could have a great impact in producing transient or permanent feelings of alienation in an individual. He noted that some individuals will maintain a high degree of hope, trust, and optimism in the face of adverse circumstances while

others may succumb quickly to the same circumstances with feelings of doubt, apathy, pessimism, and despair.

Horney (cited in Schacht, 1970; Johnson, 1973) proposed two types of alienation. The first type is alienation from the actual self. This is described as being all that one is at a given time, which is manifested by people not being in touch with their own feelings, thoughts, desires, or actions. Behavior in this situation includes people not taking responsibility for their own desires and overriding them to the point where they become indistinct and muted. The second type of alienation is described as a state in which the real self, or the most alive and real part of a person, is cut off from the positive energy that the real self represents.

Viewing the feeling experience of alienation as that which is problematic, Handwerker (1977) explored alienation as it related to the individual's perceptions. He sought answers to the questions of what it was like to be alienated, how the alienated individual feels, and how the individual experienced himself and others in his alienation. He identified two main aspects of alienation -- extra-alienation and intra-alienation. Handwerker found that there actually was only one type of alienation -- intra-alienation -- and that it found expression as both intra-alienation and extra-alienation. Extra-alienation is described as it affects interpersonal relationships, i.e., the feelings of loss and distance an individual experiences because of his separation or estrangement from other individuals and/or

groups. Intra-alienation is described as it affects the inner being of the individual, i.e., a "detachment or estrangement from, or a dissociation of one's own feelings such that the individual becomes a stranger unto himself (p. 129)."

#### Externally-Oriented References

Marx was interested in the external aspects of alienation as related to people in a modern industrial society. Marx embraced the ideas of Hegel except for the spiritual aspect; he viewed alienation as it affected people in their material working lives. Labor or working on a job was seen as a means of personal development that was a free and conscious activity, not just a means of maintaining life. Marx saw alienation as the result of people not feeling control over the quality and disposition of their products and from not feeling control over machines and other means of production. People lacked control in work as opposed to the rest of their lives over which they were assumed to have control. People in a capitalistic society were seen as being without control and had, in essence, become a commodity to be bought and sold (cited in: Bier, 1972; Schacht, 1970; Ollman, 1971; Murchland, 1971).

Fromm (1941) viewed alienation as the isolation of people from others and from nature. He referred to this as a feeling of powerlessness. People saw themselves as separate from God and from other people. In so doing individualism was gained while security and relatedness were sacrificed. To escape the feelings of

aloneness, powerlessness, and insignificance, people tended to subordinate themselves to outside powers -- to be rid of the "burden" of freedom. Fromm (1955) reiterated that people did not experience themselves as being powerful and capable but as being dependent upon others outside of self. He stated that alienation in modern society was almost complete, both in work and in consumption, and that people are surrounded by things that are not truly understood, e.g., complicated machinery. People experience themselves as "things" instead of living feeling human beings. An example of the totally alienated individual is one who is completely out of touch with self and the world, i.e., insane.

Durkheim (cited in Schaff, 1980) coined the term "anomie", which referred to a form of self-alienation that was the result of society no longer regulating or prescribing proper behavior. The individual without guidelines to follow tended to become disillusioned, anxious, and alienated (cited in Murchland, 1971). With no rules of conduct, i.e., socially approved norms to guide them, people became isolated from others with normlessness being the end result (cited in Kunungo, 1979). Alienation is the state of the person who has become estranged from his society and culture (cited in Nettler, 1957).

In 1957 Nettler conducted a study on estrangement from society as one aspect of alienation that she contended is correlated with, but different from, anomie. By having various groups of individuals answer a questionnaire she gathered data that led her to propose that alienation was positively related to

the following: creativity, mental-emotional disorder, altruism, a proclivity to suicide, a proneness to chemical addiction, to being a poor marriage risk, and that estrangement leads to criminal behavior.

In his study of 2,842 students, Hajda (1961) identified alienation as being composed of either rejection by society or rejection of society as it relates to intellectuals and nonintellectuals. He noted that, in general, a moderate to high level of alienation was found among individuals who belong to "religious ethnic, political, educational, occupational, associational, status, residential, and other minorities (p.761)."

One of the most cited conceptualizations of alienation was proposed by Seeman (1959) who identified five separate meanings that have commonly occurred in the literature. They were: powerlessness; meaninglessness; normlessness; isolation; and self-estrangement. While these categories clearly contain aspects of both an internal and external orientation the author focused on the individuals' thoughts, behaviors, decisions, and actions as they relate to external events. First, Seeman viewed powerlessness as being very close to Rotter's conceptualization of internal versus external control, and as the expectancy of the individual that his behavior cannot influence events to obtain a desired outcome. Second, meaninglessness refers to the individual not knowing who or what to believe and not being able to predict outcomes when his need for clarity is not met. Third, normlessness refers to the changing values of society and the individual's

choice of goals that may be in conflict with the values of society. The fourth type of alienation -- isolation -- is when an individual experiences rejection and does not believe that he is any longer accepted or included in activities by others. This may lead him to rebel against established goals and standards of society. Fifth, self-estrangement is when individuals experience self as alien or are unable to find rewarding activities in which to become involved and when they perceive a difference between what they would like to be and what they are. This is akin to Fromm's description of alienation: people experience themselves as alien or do not have the ability to find self-rewarding activities in which to become involved. Self-estrangement is also described as the "dissociation that occurs between unrewarding activity and the person (Seeman, 1971, p.84)."

Seeman and Evans (1962) studied alienation in hospitalized subjects in an effort to determine how learning is affected by alienation. They examined one type of alienation, powerlessness. And they found, as previously discussed, that the more alienated, i.e., powerless, an individual felt the lower their scores on an objective test of knowledge concerning their disease, the lower their rating by hospital personnel on their level of knowledge about their disease, and the less satisfaction these clients express concerning the information process within the hospital.

Seeman's (1963) next study concerned alienation as a low expectancy for control (powerlessness) among inmates in a reformatory. Those subjects with high alienation test scores were

found to score lower on a test of corrections relevant information than those subjects with low alienation test scores. The motivation to learn was found to be related not only to the expectancy one has of control of outcomes but also to the value one places on the outcomes about which the learning is relevant. Seeman found that the inmates with a longer sentence remaining had higher alienation scores than those with a shorter time remaining on their sentence and that learning improved as sentence remaining decreased. Overall the poorest learning took place in the inmates with the highest alienation scores. Roberts (1978) noted that when illness and hospitalization force individuals to give control of their lives to others that an overwhelming sense of powerlessness may result. Knowledge and learning are viewed by Roberts as a means of increasing the client's feelings of power and control.

Middleton (1963) conducted a study of alienation using a modified version of Seeman's five component conceptualization. He found that as the level of education increased feelings of meaninglessness, powerlessness, and estrangement decreased. This inverse relationship was particularly strong for meaninglessness especially among whites. Middleton suggested that the reason education seemed to have a greater effect on reducing meaninglessness in whites as compared to blacks is that whites have a greater expectancy of control within society.

Building on the works of Seeman, Davids, Hajda, Dean, and Nettler, Struening and Richardson (1965) conducted a study to

clarify the overlapping concepts of alienation, authoritarianism, and anomie. They studied 422 people in various groups ranging from the criminally insane to the adult education student, i.e., "a rough alienation-affiliation continuum" (p.769) with criminality and insanity at one end and middle class values and community involvement at the other end. The factors identified were: alienation via rejection; authoritarianism; trust and optimism; authoritarian family orientation; perceived purposelessness; conventionality; religious orthodoxy; self-determinism; and emotional distance. A large number of correlations were made supporting the investigator's contention that this study, combined with future studies and would expand and clarify relevant models.

In the proceedings of the Fifth National Conference on Nursing Diagnoses, Mills (1984) discussed alienation and the establishment of the diagnostic category of social isolation within a syndrome composed of the five types of alienation, as described by Seeman (1959) -- powerlessness, normlessness, meaninglessness, isolation, and self-estrangement. She discussed both the positive and negative aspects of alienation as being a continuum composed of solitude as opposed to loneliness and social interaction as opposed to isolation in the individual, i.e., alienation versus integration. The syndrome of alienation is also viewed as a negative energy field that Rogers (1982) described as occurring as a result of forces both inside and outside the individual.

### Positive Aspects of Alienation

Although most references to alienation have negative connotations, there are a few instances in which it is viewed in a positive way. Nettler (1957) noted that a value judgment is made by society concerning alienation and that if an individual loses himself in art or religion, society usually considers it good; however, if an individual is estranged from himself, it is usually considered bad. She also noted that Maslow had claimed that alienation was a part of a healthy personality and that it was present in every fully functioning individual in our society.

### Positive Internally-Oriented References

As the title of his chapter, "Aloneness as a healing experience (p. 54)", denotes, Suedfeld (cited in Peplau & Perlman, 1982) viewed some aspects of alienation as healthy. He mentioned profound religious experiences that some people experience while on solitary quests or voyages. He spoke of people who spend time floating in immersion tanks in darkness and silence, or in the wilderness away from other human beings. The use of reduced stimulation by people in creative professions and the use of Reduced Environmental Stimulation Therapy (REST) in psychiatric disorders and as a method to help people stop smoking was noted. Suedfeld also noted that the aversion to aloneness or isolation in modern society may be culturally prescribed and that we are only now coming to realize that future shock, noise, crowding, and

information overload, combined with a lack of privacy and solitude is unhealthy. "The antidote is solitude, stillness, and time out (p.65)", and if properly used it may overcome loneliness and promote growth.

Although usually viewed in a negative light, alienation may serve a necessary function for those who have accepted their inevitable disintegration. Kubler-Ross (1969) noted that a person who had accepted his death and found peace may detach himself from friends and loved ones. She noted that families have a great deal of difficulty in understanding the client's need to separate himself from his environment and loved ones in preparation for death.

#### Positive Externally-Oriented References

A self selected type of alienation was described by Bloch (1970), who discussed the positive aspects of privacy and its relevance for nurses in providing patient care. She saw four functions of privacy: 1) personal autonomy; 2) emotional release; 3) self-evaluation; 4) limited or protected communication. Bloch also lists four degrees of privacy: 1) solitude, or separation from the group; 2) intimacy, or acting as a part of a small group; 3) not being personally identified or supervised; and 4) creation of psychological barriers against invasion of privacy. Privacy is seen as being socially and politically determined and having different values in different cultures.

### Concept of Cancer

There is a great deal of relevance in addressing alienation in clients with cancer. The sources of confusion notwithstanding, a large number of conditions or states described above as alienation or the result of alienation can be identified in the literature concerning the client with cancer.

### Internally-Oriented References

Following the review of two years of interviews with clients, Shands, Finesinger, Cobb, and Abrams (1951) noted that "the handling of the idea of cancer is similar to other alien ideas (p.1159)," but that it is very much different in the magnitude of the reaction it provokes. The major question addressed by these researchers was to determine the effects of cancer on the emotional reactions of the client. They noted that people are normally future oriented and that they act as they do because of predictions made about the future. Cancer drastically alters all of the probabilities in the person's world and requires that he change many of his most basic attitudes about life. The amount of integration needed to adjust to their new condition is seen as being more than most clients can handle.

Mastrivito (1974) discussed the cancer client's sense of helplessness due to his extreme sense of dependency on his physician to stop the progression of his disease. The author also noted that the client may protect his family and physician by hiding his own awareness of how serious his condition is.

Harker (1972) discussed the reaction of clients' as they progressed through three different stages of their illness -- initial, advancing, and terminal. She stated that the client feels helplessness, anger that his life is threatened, and bitterness. When bitterness is expressed loved ones and family are alienated. The author also noted the self-estrangement that the client may feel because of the limitations placed on him by the disease, i.e., no longer being mobile in the work force, having health insurance limited, and feeling chained to the security of present employment. And, as noted by Hinton (1972) people with cancer also experienced alienation because they feel that others no longer care for them as individuals.

Craig, and Abeloff (1974) found that nearly one-fourth of the symptoms presented by clients with cancer were the same as those seen in clients admitted to an emergency psychiatric unit. More than one-half of the clients in their study had moderate to high levels of depression and that 30 percent had high levels of anxiety. Feelings of hopelessness, helplessness, loneliness, worthlessness, and thoughts of suicide were noted. Sobel (cited in Neuman, 1982) noted that increased mortality rates were associated with hopelessness, a major component of depression.

Smith (1985) found that clients with cancer experience loneliness and that moderate to high levels of loneliness were found in selected groups of clients in the four different stages of cancer. She viewed alienation as a subscale, or contributing factor, to loneliness.

### Externally-Oriented References

Harker and Weisman (1962) stated that clients with cancer are alienated from their familiar world and that when their illness is fatal they may experience a profound sense of loneliness. This is considered by Peplau (1979) to be the difference between a person's actual and desired amount of social interaction combined with feelings of unpleasantness.

Bahnson (1975), as noted previously, stated that cancer has a particularly negative connotation in our culture and that having cancer was socially unacceptable as compared to other illnesses. The client's response to his disease is noted to be related to the support that he has available to draw upon, i.e., how well he interacts with his physician and important others.

Barring a satisfactory answer as to what caused their cancer, clients may resort to asking who has caused their cancer. If the blame is turned inward, the client may feel guilt; if it is turned outward, toward important others, the client may alienate himself from persons very important to him at a time when he needs them the most. The client's entire system of relationships is disrupted and he is forced to adjust when his adaptive energies are at their lowest point. The client is forced into a very sudden dependent relationship with health care providers and he may react with anxiety, either showing fear or aggression. Aggression, in turn, may be either turned inward resulting in depression or outward, projected onto others (Shands, Finesinger, Cobb, and Abrams, 1951). As noted by Duldt (1981), one of the variables

closely associated with alienation is the expression of angry feelings.

Wiesman and Worden (1975) used the psychological autopsy method of studying clients with cancer, extensive premortum information was obtained on 46 clients, 35 of whom died from within four weeks to one year of the beginning of the study. Clients who survived significantly longer or shorter than a normative group from the tumor registry board were identified. The investigators found, among other things, that clients who were angry but not depressed and who maintained good relationships with others tended to survive longer. Whenever these clients expressed anger, it commanded the attention of others but was not of such a degree as to alienate them. Clients who were perceived in a negative manner by the staff, i.e., uncooperative, or who had poor interpersonal relationships, were found to have shorter survival rates.

Wortman and Dunkel-Schetter (1979) conducted an extensive review of the literature and theoretical analysis to examine the effects of cancer on clients' interpersonal relationships and the effect of these relationships on the clients' adjustment to their disease. The investigators noted that, in almost all studies examining coping and adjustment to cancer, close interpersonal relationships were associated with effective coping and poor relationship with ineffective coping. Kubler-Ross (1971) stated that if a client's family needs denial, the client will usually not talk to them about the seriousness of the illness or feelings

about the illness, but if the client knows that someone is ready to listen, denial is dropped and talk about the situation ensues.

In citing a paper presented in 1977 to the American Psychological Association by Gordon, Freidenburg, Diller, Rothman, Wolf, Ruckdeschel-Hibbard, Ezrachi, and Gerstman, the investigators (Wortman, & Dunkel-Schetter, 1979) noted that 136 clients were asked to identify if they had experienced any of the 109 most commonly reported problems expressed by cancer patients. Of the 20 most frequently noted problems seven were associated with interpersonal relationships and communication. The second most frequently mentioned problem was a lack of open communication with other family members -- which was mentioned as often as physical discomfort.

The investigators believed many of the clients' problems arose from the negative beliefs of others concerning cancer and how to treat a person with cancer. Because of fear and aversion, the client experiences avoidance and rejection by others and finds that to elicit any support at all he must present a false front and act in the manner expected by others, i.e., a positive attitude, brave and cheerful. The client with cancer is caught in a "catch 22" (p.142) in which he can express his true feelings and be rejected or can pretend that everything is fine and gain at least some support. Neither solution being ideal the client may alternate between the two types of behavior and make it even more difficult for others to know how to respond to him.

Social isolation is discussed by McGeough, Edwards, Chamberlain, and Nogeire (1980) in relation to their study of lung cancer patients. They found that as compared to clients with COPD cancer patients scored higher on measures of social isolation. Also, that the clients' physicians did not recognize the presence of isolation in their clients but could identify those who were depressed. Similarly, Singer (1983) recognized the feelings of helplessness, loneliness, social isolation, denial, and dependence that faced clients with cancer and their families. She also noted that numerous changes took place in the lives of people with cancer -- role reversals, financial difficulties, and numerous other conditions that caused denial and isolation.

Glaser and Strauss (1968) discussed the tendency to insulate or isolate a client from others toward the end of his life. Clients may wish to talk with staff, family, or minister but "not be able to reach them" (p. 168). The communication problems the client faces are not the only source of isolation. There may be an attempt to buffer the client from the knowledge of his impending death, or even if the client is aware he may engage in mutual pretense. If the client is dying in a socially unacceptable way he may be actively avoided by staff and family.

Millett (1979) stated that clients who are dying are seen as "failures" and that they were thus physically and psychologically isolated from staff, patients, and their own families. Dubrey and Terrill (1976) conducted a study of fifty cancer clients to determine their feelings of loneliness. They noted that a lack of

relationships may lead to feelings of fear, alienation, loneliness and desolation. They noted that one of the most terrifying of fears is loneliness and that "It seems one has become a stranger to himself and, consequently to others (p.358)."

Dubrey and Terrill (1976) studied fifty clients with cancer to determine their feelings of loneliness. They noted that a lack of relationships may lead to feelings of fear, alienation, loneliness, and desolation. Also, that one of the most terrifying of fears is loneliness and that, "It seems one has become a stranger to himself, and consequently to others (p. 358)."

Peplau, Miceli, and Morasch (cited in Perlman and Peplau, 1982) note that "loneliness reflects a breakdown in social interactions (p. 2)." At one end of the scale is the perception of loneliness when social relationships are less than desired. At the other end of the scale is the feeling of crowding or invasion of privacy when there is excessive social contact. Feelings of loneliness can lead to lower self-esteem or alternately low self-esteem may be accompanied by attitudes that promote loneliness. The authors also noted that when looking for love and acceptance, people may present false fronts that cause self-estrangement. Also, that individuals can usually identify a precipitating event, a maintaining cause, and can anticipate a solution for their loneliness.

Cancer has a disruptive effect on the client and his family. Future plans and roles are affected by hospitalizations and treatment. Conflict results as the individuals' attempts to cope

with the effects of the disease upon their lives (Krumm, 1982). The integrity of the family unit is threatened and helplessness is the result of feeling that all that can be done has been done (1977).

Cancer has different meanings for people depending on their culture, age, religion, developmental stage, sex, social class, roles, and so forth. In discussing the meaning of cancer, Donovan and Pierce (1976, p.4) noted that "cancer is one of the lowest status diseases in history." Cancer is considered unclean and is a social stigma. Because cancer has such negative connotations associated with it, and because of the perceived death sentence that a diagnosis of cancer carries, it is a tremendously stressful event for both the client and family.

#### The Relationship of Stress to Cancer

Stress has not yet been proven to cause cancer, but, cancer most definitely may be said to cause stress (Nevidjon cited in McIntire and Cioppa, 1984). The Oncology Nursing Society and American Nurses' Association Division on Medical-Surgical Nursing Practice (1979) have recognized the importance of managing stress by publishing outcome standards for cancer nursing practice that specifically address its management. Standard number three, coping, states: "While living with cancer, the client and family manage stress within their individual physical, psychological, and spiritual capacities and their value system (p.4)." Standard number four, comfort, states: "The client and family identify and

manage factors that influence comfort, i.e., the minimization of psychobiologic distress (p. 5)."

As noted earlier, the idea that one has cancer has a terribly disruptive effect on an individual's life because of the enormity of change that takes place. Individuals describe feeling stunned or dazed, (Shands, Finesinger, Cobb, and Abrams, 1951), or, like they are in a foreign land with language, sights, sounds, and smells all different. With their ability to handle stressful events on a daily basis greatly impaired, clients with cancer must develop support strategies to deal with their new situation and to cope effectively. "The patient who finds that cancer is not stressful and does not need support is rarely encountered" (Nevidjon cited in McIntire and Cioppa, 1984, p.561).

Donovan and Pierce (1976) noted that the stress of cancer is not only due to the threat to the client's mortality but also to several other threats which cancer represents. The authors contended that because of the nature of the American culture, people greatly fear becoming nonproductive, useless, and dependent upon others -- more so than the fear of death. Another area of great concern is the threat to one's self-image, to the physical attractiveness which is also greatly valued in our culture. Aware of their own aversion to cancer, clients fear rejection and abandonment by others. Even when the physical cure of cancer has taken place, individuals may be psychologically handicapped. As noted by Cohen (1982), after clients are diagnosed with cancer it is "never forgotten by themselves, their families, or friends and

this pronounces the cancer patient mysteriously and permanently flawed" (p. 121).

In their book on stress and how it is dealt with Lazarus and Folkman (1984) gave a thorough and authoritative account of the development of the concept. Bernard, who lived from 1917, to 1979, was noted for his contribution to the concept of stress as a adaptational process of the body that was made to restore or maintain equilibrium. The authors noted that Cannon, in 1932, used the term stress in a casual manner to refer to the a homeostatic disturbance caused by various stimuli, e.g., cold, low blood sugar, and so forth. The authors continued to say that the term stress was used in a nonsystematic way until 1936 when Selye began using the term stress to refer to a set of bodily defenses against aversive stimuli. Wolff was noted to have made a large contribution to the concept of stress in medicine when, in the 1940's and 1950's, he viewed stress as an adaptive process made in response to demands, i.e., a "dynamic state".

Lazarus and Folkman (1984) further noted that the term stress was used in the physical sciences as a passive deformation or change in a body brought about by physical loads placed upon it. However, in the biological sciences the term stress is viewed as an active process of adaptation to restore or maintain equilibrium. The concept of coping is seen as closely related to the biological conception of stress in that a person attempts to manage stress of a psychological nature. Stress cannot be viewed in just a stimulus or response framework but must take into

account individual differences in interacting with the environment. The authors defined psychological stress as a relationship with the environment that is appraised by the individual as being threatening to his well-being and beyond his ability to deal with. A similar definition of stress was given by Menaghan (cited in Kaplan, 1983) who defined stress as a mismatch between the individual's capacities and the demands of the environment or between the opportunities in the environment and an individual's goals.

Beginning in Holmes' laboratory in 1949, the quality and quantity of life events of over 5000 patients were studied to determine the effect of life events on the onset of disease. There were two categories of factors revealed: those that related to individual's life styles; and those that related to events in which the individual had been involved. It was noted that not all of the events were negative, many conformed to cultural values of success and were identified as socially desirable. However, all of the events had in common the need of the individual to adapt or cope. A scale of 43 items was devised in 1967 that measured and weighted many of the items identified in earlier studies -- these included such areas as family constellation, marriage, residence, education, religion, occupation, peer relationships, recreation and health (Holmes and Rahe, 1967; Holmes and Masuda, 1974; Holmes, 1979). Rahe (1979) noted that pleasant life events required almost the same amount of life adjustment as unpleasant life events. He noted that although there has been much

controversy that it is the social desirability, perception of unpleasantness, degree of control, and so forth, that should be measured "the superiority any of these methods over a "simple counting of the number of events, per unit time, has yet to be demonstrated convincingly" (p. 4).

Holmes and Masuda (1979) stated that a person is at risk of becoming ill when there is a life crisis, defined as a clustering of life change events, within a one year period. Rahe and Ransom (1978) noted that there was a significant relationship between a person's report of life change events and the development of minor and major illnesses and even death. Also there was a strong association between life changes and levels of psychological and physiological symptoms.

A model proposed by Rahe (Rahe, 1974; Rahe and Ransom, 1978) incorporates an individual's perceptions in explaining why an event that is stressful for one individual is not stressful for another. A person's current level of social support influences how he sees a life event, i.e., a person who finds himself without social support may view life events as more burdensome than when they have others to support them.

#### The Relationship of Alienation to Stress

Alienation has been identified as closely related to stress. And when considering stress in psychology and sociology Lazarus and Folkman (1984) noted that to speak of alienation as powerlessness, normlessness, isolation, and self-estrangement, as

Seeman does (1959, 1971), "is clearly to place alienation under the general rubric of stress." (p. 4).

Manderscheid, Silbergeld, and Dager (1976) proposed a theory that described stress as the mechanism that ties the dynamics of the social structure to syndromes of alienation. Specifically, the authors referred to the five types of alienation identified by Seeman with each variant associated with a distinct perceptual style of the individual. The authors hypothesized that psychological and physiobiochemical stress responses were positively related to one another with an increase in one causing an increase in the other. Also, that as psychological stress mounts so will the individual's perception of alienation. And that as physiobiochemical stress increased the affective component of alienation will increase. Each variant of alienation was viewed as a distinct way of coping and adapting to stress.

Seeman (1971) suggested that his redefinition of the concept of alienation has demystified the concept and has made it amenable to testing. And that we must now examine the various types of alienation and determine their consequences for society.

#### Theoretical Framework

When considering the major concepts of alienation, cancer, and stress, as developed above, it is particularly appropriate to use the health-care systems model proposed by Neuman (1982, 1980). Her model is an open system that revolves around the individual's

encounter with stressors and the responses made by the individual at various levels to deal with them.

Barriers to stress protect a person's basic structure and energy reserves, which are composed of factors that are common to the entire species, e.g., genetic response patterns, or the strength of various organs and body parts that help organisms to defend against stressors.

Stressors in Neuman's conceptualization are described as being composed of intrapersonal, interpersonal, and extrapersonal factors — however, for the purposes of this study stressors will be considered simply as either internal or external. The strength of a person's defenses determines what type of reaction will occur. The individual's defenses are described by Neuman (1982) as a dynamic state that is affected by psychosocial and biochemical conditions and also as being composed of what the person has become over time, i.e., the person's developmental stage, usual coping patterns, life style, and so forth. In a physical sense if stressors are not dealt with effectively the person's adaptive energies may be depleted to the point where death is the final response. Or, as depicted in Figure 1., a person's adaptive energies may be depleted to the point where various degrees of alienation result.

What is called a noxious stressor by one person may not be seen as such by another person. Stressors have the potential to reduce the effectiveness of a person's defenses and ability to deal with subsequent stressors. What is a normal defense for one

individual may be different for another and reflects the way a person deals with life-stresses over time.

The ability of a client with cancer to deal with stressors is affected by the numerous changes that are taking place in all areas of their life. Cancer is not a solitary experience and

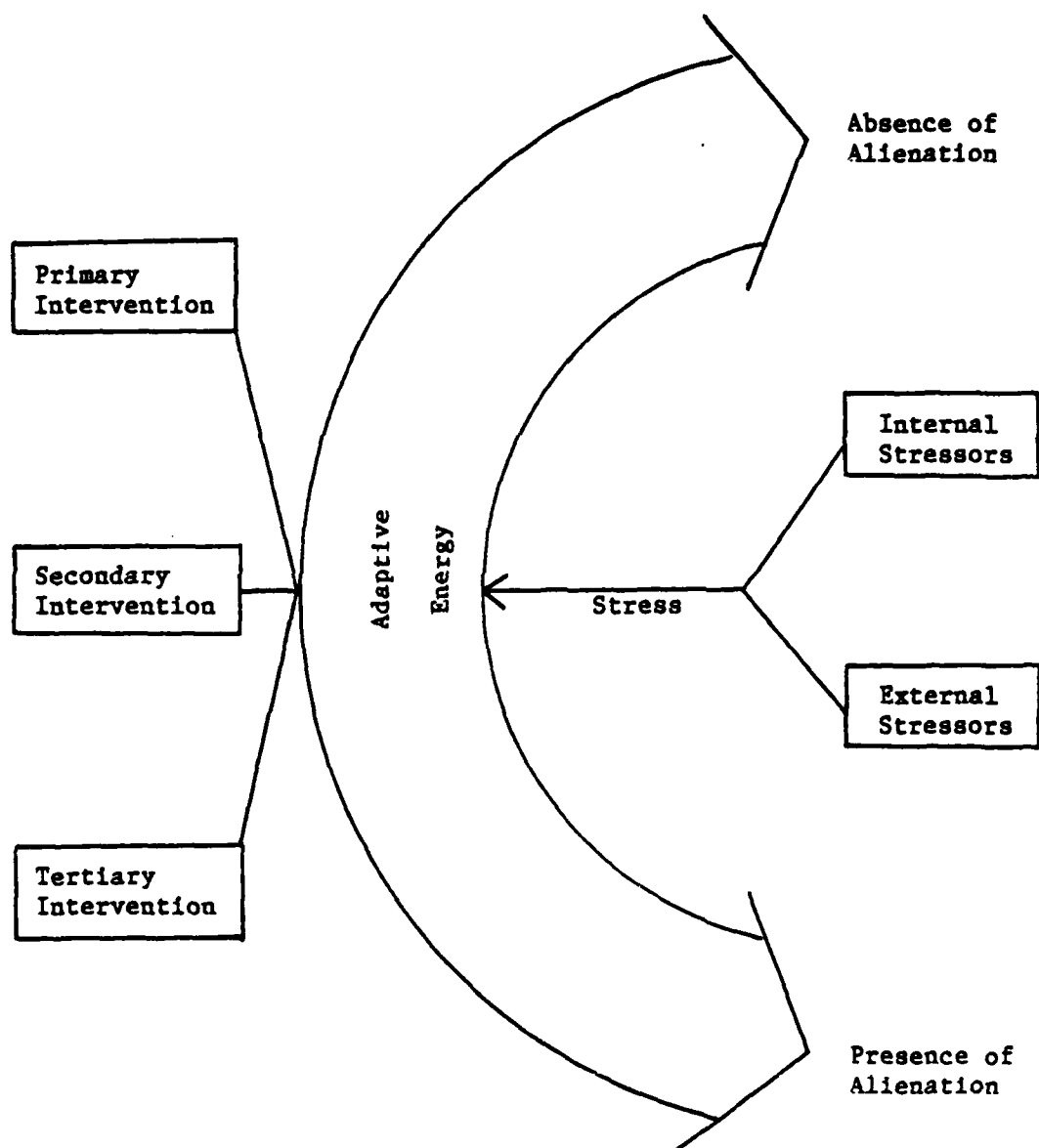


Figure 1. Stress Reaction Model of Alienation.

its negative impact on the client and important others has often been addressed in the literature as noted above. The effects of role changes, alterations in patterns of interaction between the client and others, the physical and emotional effects of the disease, and the disruption of life patterns caused by treatment appointments and hospitalizations are experienced by the clients and their important others (Krumm, 1982).

For the purposes of this study the clients' reaction to the stressors that weaken their defenses will be considered the primary factor determining the amount and type of alienation that is experienced. Adaptation to stressors may take place at any level or degree of reaction. Neuman (1981) noted that an individual both acts upon stressors and is acted upon by them. And, that each stressor affects other stressors to a certain degree. Within this gestalt conceptualization, stressors and reactions can be viewed as intrapersonal (internal), interpersonal (external), or extrapersonal (external) in nature. Physical, psychological, and sociocultural factors are contained within each of the above categories and may be used in data collection, assessment, and planning of care.

Numerous examples of intrapersonal (internal) factors were noted in the literature review. Among these were progression of the disease process, nutritional status, physical functioning, anger, fear, guilt, frustration, self-estrangement, loneliness, decreased self-esteem, culturally instilled feelings of modesty, sexual identity, and so forth. Interpersonal (external) factors

would include such areas as relationships with important others, role expectations, dependency on others, physical isolation from others, role reversals, physical care performed by others, and so forth. Extrapersonal factors would include such things as unemployment, changing residence, hospitalization, financial status, and so forth.

A wide range of responses may be made by the individual to stressors which cause alienation. At the interpersonal level an extreme physical response would be death, and an extreme psychological response would be schizophrenia. A wide range of responses somewhat less extreme would include varying degrees of self-estrangement, feelings of powerlessness, and various physical limitations. At the interpersonal level an extreme physical reaction to alienating stressors would be physical powerlessness and dependence upon others for physical care; an extreme psychological reaction would be social isolation with a resultant loneliness. If the social isolation were desired, the individual would be experiencing solitude and the isolation would not be considered a noxious stressor.

Although not explained by this study, interventions can take place at the primary, secondary, and tertiary levels and relate to a client's defenses at various levels. Primary prevention would deal with strengthening defenses prior to encountering a stressor or reducing the possibility of contact with stressors, e.g., promoting stable satisfying social support systems. The secondary level of prevention deals with early case finding and the

treatment of symptoms, e.g., noticing the lack of communication between client and family and promoting open discussion. Tertiary prevention deals with readaptation, reeducation, and maintenance, e.g., assisting a socially isolated client with cancer to find community resources and social supports.

It can be easily seen that the more changes there are in a client's life the greater are the prospects for stressors breaking through outer defenses and causing a reaction. This notion is supported in numerous studies by various experimenters (Holmes, Rahe, 1967; Holmes, Masuda, 1974; Rahe, 1979; Rahe, Ransom, 1978) — as noted above. When the social stigma and terrifying mystique of cancer is added to the very real physical threat and side effects of treatment the stage is set for conditions conducive to alienation in its various forms. Identification of alienation and its antecedents hold the promise of improving nursing care and of concomitantly improving the quality of life for the client with cancer.

#### Hypotheses

At a time when support and relatedness are of the utmost importance numerous conditions combine to alienate the client with cancer. The hypotheses for this exploratory study are that:

- 1) Subjects with cancer will report higher scores for total alienation (factor II plus factor V) than subjects without cancer.
- 2) Subjects with cancer will report higher scores for the subfactor of alienation (factor II) than subjects without cancer.

3) Subjects with cancer will report higher scores for the subfactor of estrangement (factor V) than subjects who do not have cancer.

4) Subjects who are hospitalized will report higher scores for total alienation (factor II plus factor V) than subjects who are not hospitalized.

5) Subjects who are hospitalized will report higher scores on the subfactor of alienation (factor II) than subjects who are not hospitalized.

6) Subjects who are hospitalized will report higher scores on the subfactor of estrangement (factor V) than those subjects who are not hospitalized.

7) There will be a significant difference in total alienation scores (factor II plus factor V) between subjects with cancer (hospitalized and nonhospitalized) and subjects who are hospitalized (with and without cancer).

#### Definition of Terms

Loneliness -- the difference between a person's desired and actual amount of social contact combined with negative feelings and distress because social relationships are viewed as suboptimal (Pearlman, & Peplau, 1979).

Alienation -- is an apartness or estrangement, or a disaffection of an individual from society, other individuals, and/or self (Handwerker, 1977). Alienation is represented by scores on a test of alienation composed of two subscales --

alienation (factor II) and estrangement (factor V) -- of the Belcher Extended Lonliness Scale (Belcher (1973)). The alienation subscale (factor II) expresses a lack of relatedness with others, and an isolation from the lives of others -- the focus is on others as the source or cause of the lack of relatedness. The estrangement subscale (factor V) expresses an individual's feeling that there is something wrong with the individual that interferes with establishing or maintaining desired relationships with others. In this regard, the focus is on the individual as the source or cause of the lack of relatedness (Belcher, 1973).

Factor II (alienation) -- describes alienated people as those who have intense feelings of a lack of relatedness with others and who feel that the cause for their lack of relationships is externally based (Belcher, 1973).

Factor V (estrangement) -- describes alienated people as those who feel that the cause of their unfulfilled desires for relationships is internally based (Belcher, 1973).

Stress -- as defined by Selye (1952) -- "the nonspecific response of the body to demands placed upon it."

Stressors -- any events or circumstances that are capable of breaking through or altering the effectiveness of an individual's defenses.

Cancer -- "a large group of diseases characterized by uncontrolled growth and spread of abnormal cells. If the spread is not controlled or checked, it results in death (American Cancer Society, 1983)."

Hospitalization -- the condition of being an inpatient in an acute care hospital for more than one day.

Nonhospitalization -- the condition of being an outpatient receiving care from a clinic or physician at an acute care hospital.

## CHAPTER TWO

## Methodology

Overview of Design

The purpose of this study was to explore the differences in alienation as reported by subjects in four identified groups. A comparison was made of the alienation scores among four groups of subjects, some of whom had cancer and some of whom did not have cancer. Each of the following groups had 16 subjects: hospitalized with cancer; nonhospitalized with cancer; hospitalized without cancer; nonhospitalized without cancer. The test of alienation was composed of the alienation and estrangement subscales of the Belcher Extended Loneliness Scale (BELS) (Belcher, 1979).

Instrumentation

The BELS is composed of the eight factors of pathological loneliness, loneliness anxiety, alienation, existential loneliness, estrangement, anomie, loneliness depression, and separateness. The test was developed by Dr. Belcher as part of a 1973 doctoral dissertation in clinical psychology.

The BELS was constructed from: the Bradley Loneliness Scale (LS), 1969; the 1960 Keniston Alienation Scale (AL); five questions from the Srole, 1956, Anomie Scale (AS); a Self Report Scale (SRS) developed by Belcher (1973). The validity of the individual tests was obtained through research by the authors of

the tests, and the combination of the tests was validated by Belcher (1973) and Solano (1980).

A validation study of the BELS was conducted by Dr. Belcher and consisted of comparing individual college students (N=371) who sought psychological counseling with "normals" who did not. Loneliness levels were expected to change in the group receiving the counseling but to remain the same in the control groups. The students were divided into four groups. One of two experimental groups and one of two control groups received no counseling. All groups were given the BELS as a pretest and as a posttest.

The construct validity of the BELS and its subscales was the experimental problem. A factor analysis was conducted with the expectation that the derived factors would be consistent with multiple forms of loneliness and the forms of loneliness as found in a review of the literature. The eight factors obtained accounted for 80 percent of the variance. All factor loading scores and raw scores and the total were correlated using the product-moment correlation. All were found significant at the .001 level.

An F-test of the four groups of subjects yielded a value of 13.81 ( $p < .001$ ), indicating that there were differences between the groups. A one-way analysis of variance, t-scores, an F-test, and a Tukey correction for individual means were also conducted for each factor and group. A chi-square was performed on the pre- and posttest scores of each group. The overall results of these tests indicated that the original expectations of the experimental

problem were confirmed. Each factor was then given a name consistent with its description in the literature.

As a multiple measure of loneliness the entire test was verified by Dr. Belcher; In an independent study, Solano (1980) compared the BELS to the well established UCLA Loneliness Scale validated in a test of 258 subjects. The UCLA test has been validated in multiple studies by Russel, Peplau, Cutrona, and others (cited in Perlman, & Peplau, 1982; Solano, 1980; and Smith 1985). A measure of the internal consistency of the scales revealed that the UCLA scale, on 20 items, had a coefficient alpha of .89. The BELS multi-item General Loneliness Scale, 35 items, had a coefficient alpha of .90. The alienation subscale had a coefficient alpha of .84. And the internal consistency for the total measured, 60 items, was .95.

The factors of interest to the investigator for the purpose of this study were factor II and factor V. Factor II was named alienation and described an alienated person as one who is unfriendly toward, disaffected from, or has become estranged from society. The items of this factor describe an intense feeling of a lack of relatedness with others and a rejection of lack of identity with prevalent social values. A lack of relationships is viewed by the individual as being caused by forces outside of himself and feelings that if not restricted the need for relationships could be satisfied. Factor V was named estrangement and described alienated people as those who believe themselves to be the cause of their unfulfilled desires for relationships with

others. The individuals feel that if they were doing the right things, their needs would be met.

#### Sampling Plan

A sample of convenience was obtained from two United States Air Force (USAF) hospitals. Eight subjects from each of the four groups were obtained from each location, making the total size of the sample 64.

The first USAF hospital is located near a city of 250,000 people at an Air Force Base in the northwestern part of the United States. The hospital is a 100-bed acute care facility which serves active duty military personnel, retired military personnel, and the eligible dependents of both active duty and retired personnel.

The second USAF hospital is located in the midwestern part of the United States near several small towns and cities (populations range from under 10,000 to over 40,000 persons). The hospital has approximately 150 acute care beds and offers a wide variety of outpatient services.

Subjects for the study were selected on a voluntary basis from among the clients who were either hospitalized at or visiting the clinics of the above hospitals. The criteria for selection were: 18 years of age or older, alert and oriented, aware of the diagnosis, and able to understand the items on the alienation test and a statement of acknowledgement of consent. The first eight clients in each group, at each hospital, were asked to complete the alienation test entitled Clinical Research Study (Appendix A).

Numerous attempts to contact Dr. Belcher for permission to use the BELS were unsuccessful. A letter seeking permission to use the BELS was returned marked "addressee unknown". Numerous unsuccessful telephone calls were placed to numbers provided by the Illinois Institute of Technology and to a number obtained from a professional colleague, i.e., Dr. Belcher's whereabouts are unknown. Appendix B contains a copy of the returned letter that sought permission to use the BELS.

#### Data Collection

Permission to conduct this study was obtained from the United States Air Force, through the Air Force Institute of Technology (Air University), and from the hospital commanders of institutions where data were collected. The physicians and/or nurses caring for each client were approached to determine if there was any reason the client should not be included in the study. Selection of each client was based upon the date and time of admission to the hospital or clinic, and their availability to participate in the study.

The investigator was introduced to subjects by hospital or clinic personnel and the subjects were then asked to participate in the study. The investigator asked subjects if they would take 10 to 15 minutes of their time to complete a research form. If the subject agreed to participate, the investigator then explained that participation in the study was completely voluntary and that they were under no obligation to continue unless they wished to do

so. It was also explained that the subject's name and any information given to the investigator would be held in the strictest of confidence. If the subjects wished to continue, a statement of acknowledgement of consent was provided (Appendix C). The subjects were then given the Clinical Research Study (Appendix A) to review and then were asked if there were any questions, or if there was any need for further clarification before completing the survey.

Personal information was requested and entered on the Demographic Data Form (Appendix D). The subjects were then afforded as much privacy and freedom from distraction as possible before beginning to answer the questions of the Clinical Research Study. Upon completion of the survey, they were asked to answer two open-ended questions. If subjects were unable to read the survey form or physically complete the form, the investigator read the questions to these subjects and asked them to indicate which block to mark or what answer to write down. All subjects and staff members were advised that the results of the research, in the form of an abstract, would be sent to each unit and to the department of nursing in each hospital where the research took place, and that if they wished to see the results they should inquire approximately three months after their participation in the study.

#### Data Analysis

The independent variables considered in this study were cancer and hospitalization. The dependent variable was alienation.

The dependent variable was studied from three perspectives: 1) total alienation score (factor II plus factor V), 2) internal focus of alienation (factor V, estrangement), and 3) external focus of alienation (factor II, alienation). Four groups were tested for alienation: hospitalized with cancer (Group I); nonhospitalized with cancer (Group II); hospitalized without cancer (Group III); and nonhospitalized without cancer (Group IV).

The scores on the tests measuring alienation for each of the subjects were entered on the Demographic Data Form (Appendix D). Upon completion of the data collection these scores as well as age, sex, marital status, order of birth, educational level, activity in organizations, and the variables of cancer and hospitalization were entered into a computerized statistical program (CRISP) on an IBM microcomputer. As proposed at the beginning of this study descriptive statistics were generated from the data and the mean scores of the various groups were compared to determine if there were differences among them. The groups compared were: those described above (groups I, II, III, and IV); clients with cancer (groups I and II); clients without cancer (groups III and IV); hospitalized clients (groups I and III); and nonhospitalized clients (groups II and IV). A two-factor analysis of variance (ANOVA) and F-test were done to determine if there were significant differences in alienation among the four groups based upon the variables of cancer and hospitalization. And, because of the obvious difference in means, a t-test for independent means was done between hospitalized and

nonhospitalized clients without cancer, i.e., groups III and IV. A correlation coefficient was done on all of the demographic data, test scores, and variables -- as had been originally proposed.

### Limitations

This exploratory study of alienation in hospitalized and nonhospitalized subjects had the following limitations:

1. The researcher conducted sampling in two military hospitals that did not have units specific for cancer patients or facilities for radiation therapy. Patients within the military system are often transported to the nearest military hospital that has the specialists and/or equipment needed for their care.

Therefore the sample is possibly not representative of all clients with cancer in the private sector and on oncology units.

2. Sampling was done during the holiday season, mid December to mid January. It is possible that the season of the year influences factors involving alienation.

3. The researcher used a sample of convenience of cancer and noncancer clients without controlling for specific types of cancer, acuity, or stage of disease.

4. The relatively small number of clients sampled in each group ( $n = 16$ ) precludes generalization of the results to their larger populations as a whole.

5. The researcher, as the principle investigator, may have influenced clients' responses due to the fact that he is a registered nurse and an officer in the military. As such the investigator may have been viewed as an authority figure and/or threat to those in positions of dependency and/or lower rank.

## CHAPTER THREE

FindingsDescription of the Sample

A total of 64 clients, 16 in each of four groups, were studied by this nurse researcher. Groups were composed as follows: group I, hospitalized clients with cancer; group II, nonhospitalized clients with cancer; group III, hospitalized clients without cancer; group IV, nonhospitalized clients without cancer. Twenty-four subjects were obtained at the first hospital selected for the study: 5 in group I, 3 in group II, and 8 in both groups III and IV. The remaining 40 subjects were from the second hospital selected for the study. All but five people who were asked to participate in the research did so. An acknowledgement of consent was signed by all subjects.

Each of the four groups were fairly evenly distributed on the demographic variables of age, sex, marital status, order of birth, educational level, and participation in organizations (See Tables 1 and 2). Subjects' ages ranged from 19 to 71 years with a mean of 46.5 years, the mean age for all subjects with cancer was 49.56 years and 43.5 years for subjects without cancer. There were 37 males and 27 females; 49 were married and 15 were single. The data on sex, age, and marital status divided by group membership are presented in Table 1.

Table 1. Sex, Range of Age, Mean Age, and Marital Status by Group.

|       |     | Frequency |   | Mean Age |      | Range of Age |       | Married Clients |   |
|-------|-----|-----------|---|----------|------|--------------|-------|-----------------|---|
|       |     | M         | F | M        | F    | M            | F     | M               | F |
| Group | I   | 8         | 8 | 48.2     | 53.6 | 29-65        | 25-70 | 6               | 6 |
| Group | II  | 11        | 5 | 53.8     | 35.8 | 38-69        | 22-49 | 9               | 4 |
| Group | III | 8         | 8 | 44.2     | 40.7 | 33-60        | 19-66 | 4               | 6 |
| Group | IV  | 10        | 6 | 48.7     | 37.5 | 27-71        | 24-66 | 2               | 0 |

M = Male, F = Female

Educational levels ranged from 8 to 19 years. The mean was 13.4 years with only three clients having less than 12 years of education. Forty subjects were active in organizations and 24 subjects were not. Presented in Table 2, are the data pertaining to the clients' educational levels and activities in organizations.

Table 2. Educational Level and Organizational Activity by Group.

|       |     | Range of<br>Education | Mean<br>Education | Active in<br>Organizations |       |
|-------|-----|-----------------------|-------------------|----------------------------|-------|
|       |     |                       |                   | Men                        | Women |
| Group | I   | 11 to 15 yrs.         | 13.0 yrs.         | 6                          | 2     |
| Group | II  | 12 to 16 yrs.         | 13.5 yrs.         | 5                          | 4     |
| Group | III | 11 to 16 yrs.         | 13.0 yrs.         | 6                          | 5     |
| Group | IV  | 8 to 19 yrs.          | 14.0 yrs.         | 7                          | 5     |

The mean scores of the tests are presented in Table 3. The group IV mean scores were the lowest in all three tests. Group III had the highest score in total alienation and in the test for factor V, estrangement. Group II scored highest in the test for factor II, alienation.

Table 3. Total and Factor Mean Alienation Scores by Group.

|       |     | Total<br>(subfactors combined) | Factor II<br>(alienation) | Factor V<br>(estrangement) |
|-------|-----|--------------------------------|---------------------------|----------------------------|
| Group | I   | 69.25                          | 46.93                     | 22.31                      |
| Group | II  | 71.87                          | 47.50                     | 24.37                      |
| Group | III | 72.31                          | 46.75                     | 25.56                      |
| Group | IV  | 59.81                          | 40.94                     | 18.87                      |

The total alienation score (factor II plus factor V) grand mean for males was 71.56, the mean score for male clients with cancer was 67.84, and for male clients without cancer 67.9. The grand mean for women was 63.85, the mean score for women with cancer was 74.54, and for women without cancer the mean score was 53.93. Presented in Table 4. are the total alienation mean scores for men and women by group membership.

Table 4. Total Mean Alienation Scores for Men and Women by Group.

|           | Men   | Women |
|-----------|-------|-------|
| Group I   | 58.62 | 79.87 |
| Group II  | 74.54 | 66.00 |
| Group III | 89.87 | 54.75 |
| Group IV  | 64.00 | 52.83 |

Alienation scores are further broken down, in Table 5, into three groupings that range from extremely high to low. 75% of the scores for clients in groups I, II, and III fall within the 43 to 86 total score range, whereas 87% of the scores for clients in group IV fall within this same range.

Table 5. Frequency of Total Alienation Scores by Group.

|                | Group I | Group II | Group III | Group IV |
|----------------|---------|----------|-----------|----------|
| High to        |         |          |           |          |
| Extremely High |         |          |           |          |
| 120 to 130     | 0       | 0        | 1         | 0        |
| 109 to 119     | 2       | 2        | 0         | 0        |
| 98 to 108      | 0       | 0        | 0         | 0        |
| Moderate to    |         |          |           |          |
| Mod. High      |         |          |           |          |
| 87 to 97       | 1       | 0        | 3         | 2        |
| 76 to 86       | 2       | 6        | 1         | 0        |
| 65 to 75       | 2       | 2        | 6         | 3        |
| Low to Mod.    |         |          |           |          |
| 54 to 64       | 7       | 3        | 2         | 4        |
| 43 to 53       | 1       | 1        | 3         | 7        |
| 32 to 42       | 1       | 2        | 0         | 0        |

An analysis of variance (ANOVA) was done on total alienation scores for the factors cancer and hospitalization. No significant results were found among the four groups at  $p < 0.05$  (Table 6).

Table 6. ANOVA of Total Alienation Scores for the Variables of Cancer and Hospitalization.

| Source                   | df | SS        | MSS     | F     | p      |
|--------------------------|----|-----------|---------|-------|--------|
| Between                  | 63 | 24043.750 | --      | --    | --     |
| Cancer (Gr I & Gr II)*   | 1  | 324.000   | 324.000 | 0.867 | 0.3554 |
| Hosp. (Gr III & Gr IV)** | 1  | 390.063   | 390.063 | 1.044 | 0.3109 |
| Ca x Hosp                | 1  | 915.062   | 915.062 | 2.449 | 0.1228 |
| Error Within Groups      | 60 | 22414.625 | 373.577 | --    | --     |

\* Groups I & II included all subjects with cancer, hospitalized and nonhospitalized.

\*\* Groups III & IV include all subjects hospitalized, with and without cancer.

A two-factor ANOVA for the factor II (alienation) subscale was not found to be significant at  $p < 0.05$  for the variables of cancer and hospitalization (Table 7).

Table 7. ANOVA of Factor II (alienation) Scores for the Variables of Cancer and Hospitalization.

| Source                 | df | SS       | MS      | F     | P     |
|------------------------|----|----------|---------|-------|-------|
| Between                | 63 | 9961.937 | --      | --    | --    |
| Cancer (Gr I & Gr II)  | 1  | 182.250  | 182.250 | 1.188 | 0.280 |
| Hosp. (Gr III & Gr IV) | 1  | 110.250  | 110.250 | 0.718 | 0.400 |
| Ca x Hosp.             | 1  | 162.562  | 162.562 | 1.059 | 0.307 |
| Error Within Groups    | 60 | 9206.875 | 153.448 | --    | --    |

Presented in Table 8 is a two-factor ANOVA for the factor V (estrangement) subscale which was found to be significant at  $p < 0.05$  for the interaction between cancer and hospitalization.

Table 8. ANOVA of Factor V (estrangement) Scores for the Variables of Cancer and Hospitalization.

| Source                 | df | SS        | MS       | F     | p       |
|------------------------|----|-----------|----------|-------|---------|
| Between                | 63 | 5056.9375 | ---      | ---   | ---     |
| Cancer (Gr I & Gr II)  | 1  | 20.2500   | 20.2500  | 0.262 | 0.6109  |
| Hosp. (Gr III & Gr IV) | 1  | 85.5625   | 85.5625  | 1.105 | 0.2973  |
| Ca x Hosp.             | 1  | 306.2500  | 306.2500 | 3.956 | 0.0513* |
| Error Within Groups    | 60 | 4644.8750 | 77.4146  | ---   | ---     |

\*  $p < 0.05$

Mean scores for subjects with cancer (groups I & II) are higher than the scores for subjects without cancer (groups III & IV) for both subfactor and combined scores alike (Table 9).

Table 9. Mean Scores of Subjects With Cancer and Subjects Without Cancer.

|                                              | n  | Alienation Score Means |           |           |
|----------------------------------------------|----|------------------------|-----------|-----------|
|                                              |    | Total                  | Factor II | Factor IV |
| Subjects with Cancer<br>(Groups I & II)      | 32 | 70.56                  | 47.22     | 23.34     |
| Subjects without Cancer<br>(Groups III & IV) | 32 | 66.06                  | 43.84     | 22.22     |

Table 10 presents the mean alienation scores of hospitalized subjects (Groups I & III) compared to nonhospitalized subjects (Groups II & IV). Subjects who are hospitalized have higher scores than nonhospitalized subjects for factor II, factor V and total alienation scores.

Table 10. Mean Scores of Subjects Hospitalized verses nonhospitalized.

|                                              | n  | Alienation Score Means |           |           |
|----------------------------------------------|----|------------------------|-----------|-----------|
|                                              |    | Total                  | Factor II | Factor IV |
| Hospitalized Subjects<br>(Groups I & III)    | 32 | 70.78                  | 46.84     | 23.93     |
| Nonhospitalized Subjects<br>(Groups II & IV) | 32 | 65.84                  | 44.22     | 21.63     |

### Hypotheses Considered

The hypotheses for this exploratory study were as follows:

1) Subjects with cancer will report higher scores for total alienation (factor II plus factor V) than subjects without cancer.

This hypothesis was supported by data presented in Table 9.

Subjects with cancer had a mean score of 70.56 while subjects without cancer had a mean score of 66.06.

2) Subjects with cancer will report higher scores for the subfactor of alienation (factor II) than subjects without cancer.

This hypothesis was supported by the data in Table 9. Subjects with cancer had mean factor II scores of 47.22 while subjects without cancer had mean factor II scores of 43.84.

3) Subjects with cancer will report higher scores for the subfactor of estrangement (factor V) than subjects without cancer. This hypothesis was supported by mean factor IV scores in Table 9. The subjects with cancer had mean scores of 23.34 and the subjects without cancer had mean scores of 22.22.

4) Subjects who are hospitalized will report higher scores for total alienation (factor II plus factor V) than subjects who are not hospitalized. This hypothesis was supported by the data in Table 10. Subjects who were hospitalized had mean scores of 70.78 as compared to mean scores of 65.84 for subjects who were not hospitalized.

5) Subjects who are hospitalized will report higher scores for the subfactor of alienation (factor II) than subjects who are not hospitalized. This hypothesis was supported by the data in Table 10. Hospitalized subjects had mean scores for factor II of

46.84 as compared to mean factor II scores for nonhospitalized subjects of 44.22.

6) Subjects who are hospitalized will report higher scores for the subfactor of estrangement (factor V) than subjects who are not hospitalized. This hypothesis was supported by data in Table 10. Hospitalized subjects had mean estrangement (factor V) scores of 23.93 whereas nonhospitalized subjects had mean scores of 21.63.

7) There will be a significant difference in total alienation scores (factor II plus factor V) between subjects with cancer (hospitalized and nonhospitalized) and subjects who are hospitalized (with and without cancer). This hypothesis failed to be supported by data in Table 6. The two-factor ANOVA did not reveal significance at  $p < 0.05$ .

#### Additional Findings

By grouping the data in Table 5 it was found that 80% of all high to extremely high alienation scores belonged to subjects with cancer as compared to 20% for hospitalized subjects without cancer and nonhospitalized noncancer subjects combined. Further analysis revealed that subjects in each of the four groups experienced a moderate to moderately high degree of alienation while other subjects in these same groups experienced only a low to moderate amount of alienation.

A Pearson correlation (Table 11) was conducted on all of the variables and scores mentioned above comparing them with all other factors, i.e., factor II; factor V; total alienation test score; age; sex, marital status, order of birth, educational level;

membership in organizations; cancer; and hospitalization status.

The results of these analyses revealed a significant positive relationship between the subfactors of the alienation test (alienation and estrangement) and each subfactor and the total test score. There was also a significant negative relationship found among all scores of the alienation test and membership in organizations -- Table 5 gives a summary of those findings that were significant.

Table 11. Significant Correlations Among All Factors and Scores.

|                             | Factor II                       | Factor V                        | Total Score                        |
|-----------------------------|---------------------------------|---------------------------------|------------------------------------|
| Factor II                   | ----                            | $r = 0.6670$<br>$p = 0.0000$    | $r = 0.9398$<br>$p = 0.0000$       |
| Total Score                 | ----                            | $r = 0.8814$<br>$p = 0.0000$    | ----                               |
| Membership in Organizations | $r = -0.3185$<br>$p = 0.0103^*$ | $r = -0.3168$<br>$p = 0.0108^*$ | $r = -0.3472$<br>$p = 0.0049^{**}$ |

\*  $p < 0.010$

\*\*  $p < 0.005$

Because of the differences in the mean scores in Tables 3 and 4 of noncancer clients, based upon status as being hospitalized versus nonhospitalized, a t-test for independent means was conducted on groups III and IV with the result that significance was found at  $p < 0.05$  using a 2-tailed test (See Table 12).

Table 12. T-test of Independent Means for Hospitalized and Nonhospitalized Clients Without Cancer.

|           | N  | m     | d.f. | t      |
|-----------|----|-------|------|--------|
| Group III | 16 | 72.31 | 30   | 2.148* |
| Group IV  | 16 | 59.81 |      |        |

\*  $p < 0.05$  (two-tailed)

t-critical = 2.042

Answers to the open-ended questions (Appendix A) were examined and categorized patterns were identified. The first question asked the subject to focus on the ways in which relationships are formed with others. Subsection "a" of question number one asked what traits within the subject possibly hindered establishing and maintaining relationships with others. Of all responses, 36% cited personal behavior as the reason for problems, while 36% cited personal beliefs as the source of difficulty. Emotions and/or feelings were noted in 24.2% of the remaining responses. The last 3.8% did not fit into the above groups nor did they appear related to each other.

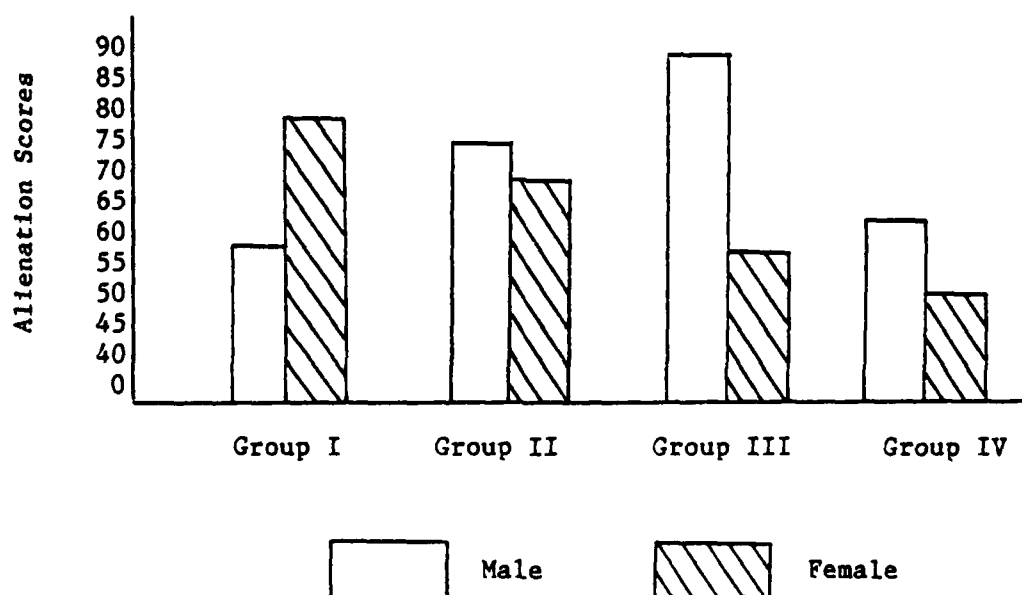
In subsection "b" of question number one clients were asked to consider the causes outside of themselves that hindered establishing and maintaining relationships. Employment, illness/disability, and location of residence accounted for approximately equal portions of 51% of the responses. The behavior of others and the beliefs of others were cited in 23% of the responses. Lack of a support group and separation from important others made up another 1% of responses. The remaining responses (25%) referred to internal traits as requested in question 1 a.

Question two asked that each client think of a time when they were lonely and describe the cause of that loneliness as accurately as possible. Thirty-six percent of responses indicated that separation from important others was the cause of loneliness while another 34% cited the death of a loved one, lack of a support group or divorce as the cause of their loneliness. Twelve

and one-half percent identified illness/disability and loss of control of their lives as an important contributor to loneliness while 8% noted sad thoughts as being responsible for their loneliness. The remaining responses (9.5%) were varied and unclear as to categorization. Nineteen subjects, 6 females and 13 males, chose to answer the question with "none" or "can't remember such an occasion." These clients had a total alienation score mean of 75.35 which is 13 points higher than the overall mean score and 3 points higher than the next highest group score, i.e., group III with a mean of 72.312 (See Table 3).

When subjects' total alienation mean scores are categorized according to gender (See Table 13) it is evident that the scores of the female subjects stair-step down an alienation gradient while those of the male subjects do not show a consistent gradient in either direction.

Table 13. Histogram of Male and Female Alienation Test Scores.



### Discussion of Findings

This study was conducted at two United States Air Force (USAF) hospitals, one in the northwestern part of the United States (US) and the second in the midwest. The client population served by these facilities represent a cross section of persons from throughout the country. Military members enlist or are commissioned into service in all of the 50 states and from other US possessions and travel to military bases throughout the US and the world. Clients were either active duty military members, retired from the military, or the dependents of active duty or retired personnel.

Many clients had extensive support groups whereas others had little or no support group other than health care personnel. One active duty 36 year old client with cancer had so many family and church members visiting with him that it was mutually decided by him and the professional nurses caring for him to limit the number of visitors so that he would have adequate periods of time for rest. In another case a 25 year old active duty member's cancer was discovered upon arrival at the hospital for a physical examination while enroute to a remote duty assignment. This client had no family friends or even acquaintances in the area during diagnosis, surgery, or recovery.

Another factor related to the availability of support groups is the practice of aeromedical evacuation, i.e., clients are flown to other military medical facilities if the services or specialists they require are not provided at the hospital where they are seeking care. Although the researcher did not

specifically request information concerning the proximity of support group members with whom the clients could share thoughts and feelings the availability of such persons may have a relationship to the degree of alienation experienced.

The researcher hypothesized that the scores for total alienation factor II (alienation) and factor V (estrangement) would be greater in cancer patients than in patients without cancer. Hypotheses 1, 2, and 3 were supported by the data in Table 9 which revealed factor II and factor V and total mean scores that were higher for cancer patients than for noncancer patients. Even though hypotheses one, two, and three were supported, it should be noted that neither of the hospitals where the study was conducted had an inpatient cancer unit, only one had an oncologist, and there was no radiation therapy available at either hospital. Therefore clients who needed an extensive workup and/or radiation therapy were sent to larger USAF medical centers that could provide the necessary specialists and therapies. Retrospectively, the nurse researcher notes that although his wife was stationed at a 150 bed hospital she was sent 1000 miles from home for such a diagnostic workup, surgery, and radiation therapy.

In hypotheses 4, 5, and 6 the researcher suggested that hospitalization was a critical factor in the cause of alienation. Results of this study supported those hypotheses (See Table 10).

Hypothesis 7 was developed in an effort to compare the impact of hospitalization with the impact of cancer upon the scores for alienation. Results of these studies failed to clearly support the identification of a significant difference between the

contribution of either of these factors to alienation. However, data also indicated that the interaction of hospitalization and the presence of cancer was significant ( $p < 0.05$ ) in the factor V (estrangement) score.

Other factors that must be considered when attempts are made to generalize the findings of this study to a larger population include the time of the year (season) and the acuity levels of the patients and treatments. sample should also be noted. The majority of nonhospitalized clients with cancer that were surveyed were receiving chemotherapy. The study was conducted during the holiday season, mid December through mid January. Subjects in the study were receiving only absolutely necessary medical care. The sample may have had a larger proportion of clients who were more ill than those not receiving care during the holidays.

The t-test results (Table 10) for hospitalized noncancer and nonhospitalized noncancer clients may reflect a more accurate picture of the effects of hospitalization on alienation while the results of the overall sample may have been influenced by the atypical nature of the cancer client population. Also it should be noted that the only clients who refused to participate in the study did not have cancer. Although many of the clients with cancer did not feel well, were in pain, or were receiving chemotherapy they were all willing to participate. It is possible that clients with cancer feel much more dependent, especially those who are hospitalized. And therefore these clients wish to present, as the literature suggests, a "good patient" image of cooperation and optimism and may deny their true feelings. One

cancer client with an extremely low alienation score had a very large inoperable neck tumor. And although this client had an abrupt manner and spoke in a hostile tone of voice he said only "good things" about the care he was receiving and how he was not worried about his condition "because it is better to be with God anyhow." This scenario may represent the inner conflicts that patients may be experiencing in this type of situation.

The significant positive correlation between the total alienation test score and the subfactor scores (Table 11) is in agreement with the results found by Belcher (1973). Significant correlations were found among all eight factor scores and the total score of the Belcher Extended Loneliness Scale (Belcher, 1973).

As previously noted participation in organizations is negatively correlated with alienation scores at a significant level. This finding supports the findings of Smith (1985) that loneliness and group membership were negatively correlated. The low level of alienation expressed by those active in organizations may be due to their ability to participate. 53% of clients with cancer were active in organizations as compared to 72% of those without cancer. The demands placed on an individual's life by a major illness such as cancer may severely limit the time and energy necessary for participation in organizations. It should be noted however that numerous clients with cancer mentioned their faith in God as being a sustaining factor for them and that of all those reporting active participation in organizations 42% mentioned church membership -- more than one and one half times

greater than the next most frequently mentioned category of organization membership.

The relatively high mean alienation score for those clients who claimed not to have had a lonely time that they can remember may be indicative of their denial of feelings of loneliness. It is also possible that the representation of mean scores in the histogram of mean scores for men and women (Table 11) might indicate denial of feelings by men and/or their inability to express their feelings when in an extremely dependent and threatening situation, i.e., having cancer. An alternate explanation is that men become less alienated when they have cancer because once they have assumed the sick role they are "given permission" to express themselves and are given emotional support -- especially because of the protracted nature of their disease. The relatively high mean scores of male clients who are hospitalized without cancer may be an indication that mildly dependent positions encourage men to express dissatisfaction but do not decrease alienation. The stair-stepping of mean scores for females is a possible indication of the relative ease with which women express their feelings as compared to men. The scores of women may be a more true representation of the amount of alienation produced by increasingly more threatening and disruptive conditions. Such findings were originally hypothesized for the entire population of men and women combined, i.e., that cancer and hospitalization do influence alienation.

Overall clients were interested in participating in the researcher's study and in helping to improve care for clients with cancer. As one client with cancer said "sure I'd be glad to help, maybe some good can come out what is happening with me."

## CHAPTER FOUR

## SUMMARY AND RECOMMENDATIONS

Summary

This exploratory research study examined alienation in four groups of clients: hospitalized with cancer; nonhospitalized with cancer; hospitalized without cancer; and nonhospitalized without cancer. The purpose was to study the alienation scores of subjects with cancer and without cancer and hospitalized and nonhospitalized. And to increase understanding of the importance of attention to alienation for improving the care of clients with cancer. Sixty-four clients (37 males and 27 females), 16 in each of the four groups participated in the study. Factor II (alienation) and factor V (estrangement) of the eight-factor Belcher Extended Loneliness Scale were combined and administered to provide a measure of the client's total alienation.

This study proposed 7 hypotheses: 1) Subjects with cancer will report higher scores for alienation and estrangement than subjects without cancer; 2) Subjects with cancer will report higher scores for the subfactor of alienation (factor II) than subjects without cancer; 3) Subjects with cancer will report higher scores for the subfactor of estrangement (factor V) than subjects without cancer; 4) Subjects who are hospitalized will report higher scores for alienation and estrangement than subjects who are not hospitalized; 5) Subjects who are hospitalized will report higher scores for the subfactor of alienation (factor V) than subjects who are not hospitalized; 6) Subjects who are

hospitalized will report higher scores for the subfactor of estrangement (factor V) than subjects who are not hospitalized; 7) There will be a significant difference in total alienation scores (factor II plus factor V) between subjects with cancer (hospitalized and nonhospitalized) and subjects who are hospitalized (with and without cancer).

Hypotheses 1, 2, and 3 were supported by mean scores for subjects with cancer that were higher for factor II, factor V, and total alienation (factor II plus factor V) than the scores of subjects without cancer. Hypotheses 4, 5, and 6 were supported by mean scores for hospitalized subjects that were higher for factor II, factor V, and total alienation scores than the scores of subjects who were not hospitalized. Hypothesis 7 was not supported at  $p < 0.05$  in a two-factor analysis of variance (ANOVA) of total alienation scores for the variables of cancer and hospitalization. However, data for a two-factor ANOVA conducted on the factor V (estrangement) subfactor did reveal significance at  $p < 0.05$  the interaction between cancer and hospitalization.

### Recommendations

Studies on alienation in the future should consider the following recommendations.

1. Subjects should be chosen at large USAF medical centers that offer all specialties and treatments necessary for the care of clients with cancer. An increase in the size of the sample

would strengthen the findings. Ideally replications should be conducted at civilian medical treatment facilities.

2. A study should be conducted comparing subjects traveling within the military aeromedical evacuation system to compare their degree of alienation to that of the military population who receive health care near their place of residence.

3. A study of hospitalized and nonhospitalized clients should be conducted controlling for diagnostic categories.

4. Demographic data should include information concerning the proximity of the client's support group, the number of persons in that group, the relationships of these persons to the client, and whether the client believes that needs for relating to others are being met.

5. Further studies of clients with cancer should include more information on the clients condition, i.e., diagnosis, stage of the disease process, disfigurement and/or surgical procedures, and the types of treatments being administered prior to and during the time of testing.

6. A study of selected clients with and without cancer should be conducted longitudinally to determine the presence or absence of changes during progression of their illness, from first diagnosis through recovery or until death.

7. The amount of life change stress that subjects are experiencing should be measured by the Schedule of Recent Experience by Amundson, Hart, and Holmes (1981) and correlated with the results of a test of alienation.

8. This study should be replicated with paired samples of men and women controlled for diagnostic category, stage of disease, hospitalization status and age.

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**Appendix A**

## CLINICAL RESEARCH STUDY

A Test of Alienation -- factor II (alienation) and factor V (estrangement) -- adapted from the Belcher Extended Loneliness Scale by Belcher (1973).

## Instructions

1. Answer each question by filling in one space in the six position answer column. Notice that the first or left hand side is entitled RARELY OR ALMOST NEVER TRUE FOR ME and the right hand side is entitled TRUE FOR ME ALL OR MOST OF THE TIME. To answer each question, mark one of the six columns which most closely approaches your feelings.

2. Be sure to answer each question. there is no time limit. There is no right or wrong answer. YOUR FEELINGS ARE IMPORTANT.

## EXAMPLE:

Rarely or almost  
never true for me.

True for me all or  
most of the time.

1. When others voice an opinion contrary to what I believe, I say nothing.

|  |   |  |  |  |  |
|--|---|--|--|--|--|
|  | X |  |  |  |  |
|--|---|--|--|--|--|

Client's Code Number \_\_\_\_\_

Rarely or almost  
never true for me.

True for me all or most of the time.

1. It's impossible to find anyone who will accept you for what you are.
2. These days a person doesn't really know whom he can count on.
3. If you have faith in your friends, they will seldom disappoint you.
4. People are basically good.
5. To avoid disappointment a person has to expect the worst from other people.
6. I do not expect much help or praise or sympathy from other people.
7. In the long run things usually work out for the best.
8. I have no one to depend on but myself.
9. Most friendships end with disappointment.
10. I cannot discuss my problems with anyone.
11. A person should plan his life so he doesn't have to count on others.
12. Most people are pretty alone and friendless.
13. The lot of the average man is worse, not better.
14. Very few people can be trusted.
15. Nice as it may seem to have faith in other people, it doesn't pay off.

**Rarely or almost  
never true for me.**

True for me all or most of the time.

16. You can count on most people you meet.
17. The world is full of people who will take advantage of you.
18. There are always plenty of people to lend a hand.
19. People enjoy my company.
20. People do not seem to notice that I am around.
21. People do not like me.
22. I feel terrible when I know that someone is watching me.
23. When I am around a group I feel like I don't belong.
24. When I am in a group I feel like a small fish in a large fishbowl.
25. I feel free to just be myself around other people.
26. It's hard for me to get out of bed and face the prospects of the day.
27. I feel like I don't have a world of my own.
28. People would think that I was foolish if they really knew me.

[illegible]

### Open-Ended Questions

I. Focus for a minute on the way in which you form relationships with others.

a) What personal traits (within yourself) may hinder establishing and maintaining relationships with others?

b) What causes (outside yourself) may hinder establishing and maintaining relationships with others?

II. Think back to a time when you experienced feeling lonely. List possible causes (e.g. persons, places, things, situations) that may have brought about the feeling of loneliness.

Appendix B

From:  
Ronald E. Rydgren, BSN, RN  
309 Howard Avenue  
O'Fallon, Illinois 62269

2 June 85

Subject:  
Request for permission to use the  
Belcher Extended Loneliness Scale (BELS).

To:  
Dr. Michael J. Belcher  
1707 South Country Club Road  
Decatur, Illinois 62523

Dear Dr. Belcher:

I am a student in the Graduate School of Nursing at Southern Illinois University at Edwardsville, Illinois and I am working on a Master of Science Degree in Medical-Surgical Nursing. And, I am at this time preparing to do research for my thesis.

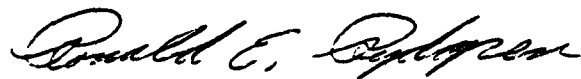
For several years I have worked with people who have cancer and have been impressed by the alienation that they experience. In a recent review of the literature I found very few studies that mention alienation in people with cancer, and among those I did find none were from within the field of nursing.

I have decided to do my thesis on alienation in persons with cancer, because of personal interest, a desire to add to the body of nursing knowledge, and to improve the nursing care of clients with cancer. The study I propose to do deals with four groups of clients: hospitalized with cancer; nonhospitalized with cancer; hospitalized without cancer; nonhospitalized without cancer. I

believe that parts of the tool which you developed, the BELS (1973), would be of great value in testing for the presence of alienation in the above four groups.

I request that I be granted your permission to use the BELS in my research. I will be happy to send you a copy of the results of my study once it has been completed.

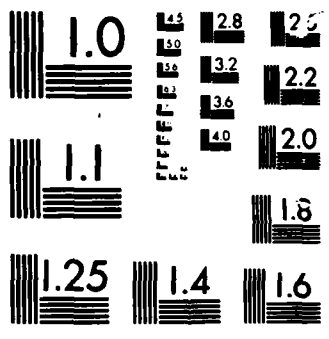
Respectfully,

A handwritten signature in cursive script, reading "Ronald E. Rydgren". The signature is written in dark ink and is positioned above the typed name.

Ronald E. Rydgren, BSN, RN

AD-A166 850 AN EXPLORATORY STUDY OF ALIENATION IN HOSPITALIZED AND 2/2  
NONHOSPITALIZED CL. (U) AIR FORCE INST OF TECH  
WRIGHT-PATTERSON AFB OH R E RYDGREN MAR 86  
UNCLASSIFIED AFIT/CI/NR-86-231 F/G 5/10 NL





MICROCOPY

CHART

## Appendix C

## Acknowledgement of Consent

I hereby agree to cooperate and participate in a research project entitled A Clinical Research Study of Hospitalized and Nonhospitalized Patients to be conducted by Ronald E. Rydgren as the principle investigator.

I understand that:

1. All of the research data will be collected and analyzed in a strictly confidential manner.
2. Nothing I do will place me in physical danger, and I will be warned of any other risk.
3. Experimental procedures will be explained to me prior to their administration.
4. I may ask questions of the researcher and expect pertinent answers.
5. I may refuse to participate in the study or may discontinue participation at any time without prejudice, question, or reprimand.
6. Benefits of the research to me or others will be explained.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Experimentor's Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

## Appendix D

## Demographic Data

Client's Initials: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Order of Birth: \_\_\_\_\_ Education: \_\_\_\_\_

Cancer: \_\_\_\_\_ No Cancer: \_\_\_\_\_

Hospitalized \_\_\_\_\_ Not Hospitalized: \_\_\_\_\_

Organizations in which active: \_\_\_\_\_  
\_\_\_\_\_

Score on Alienation Test: \_\_\_\_\_

Client's Code Number: \_\_\_\_\_

END  
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