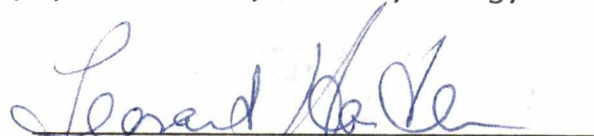
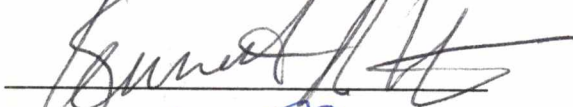


To the Graduate Council:

I am submitting herewith a dissertation written by Susan Carol Feinberg entitled "Object Relations and the Capacity to be Alone." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.


Leonard Handler, Major Professor

We have read this dissertation
and recommend its acceptance:


Accepted for the Council:


Vice Provost
and Dean of The Graduate School

4

OBJECT RELATIONS AND THE CAPACITY
TO BE ALONE

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Susan Carol Feinberg
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ABSTRACT

The study was designed primarily to test a hypothesis based on the object relations literature, particularly Winnicott's discussion of the capacity to be alone. That is, high tolerance of physical aloneness in adults should be associated with relatively healthy and mature internal representations of the self and others, while low tolerance of physical aloneness should be associated with developmentally less mature internal representations.

Subjects--56 adult outpatients--were interviewed about their tolerance of aloneness: the nature of discomfort experienced in aloneness, behavioral responses to the discomfort, amount of time spent in physical isolation, and relation of moods to experience of aloneness. This information was (1) summarized as a source of phenomenological data, and (2) used as a screening method to select the two experimental groups: the group with high tolerance for aloneness and the group with low tolerance for aloneness. Selection was based on agreement between raters of the interview transcripts and the subjects' therapists' ratings. Three sources of projective data were then collected from each experimental subject: early memories, stories in response to the Object Relations Technique, and dreams. Dreams and early memories were scored by Krohn's Object-Representation Scale for Dreams; Object Relations Technique stories did not prove amenable to scoring by this system, and were instead scored by a system developed by the author.

Results provided partial support for the primary hypothesis. More high tolerance subjects obtained scores on their early memories which were above the overall mean than did low tolerance subjects. High tolerance subjects were more likely to score high scores and low tolerance subjects were more likely to score low scores on both dreams and early memories. Scores on ORT stories, however, showed no significant differences between groups.

In addition, phenomenological data suggested that situational factors (divorce, assault, relocation, for example) seem to account for reductions in tolerance of aloneness, in addition to the more long-standing degree of internal object representation development.

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CHAPTER 1

INTRODUCTION

D. W. Winnicott first used the phrase "The Capacity to Be Alone" as a title of a paper published in 1958. In this paper he developed several critical concepts. He distinguished the capacity to be alone from the negative notion of withdrawal from people. He saw the capacity to be alone, or, as Guntrip put it, the capacity to "enjoy privacy" (Guntrip, 1969) as "one of the most important signs of maturity in emotional development" (Winnicott, 1958, p. 416).

For Winnicott, the capacity to be alone became a complex concept. He was not referring simply to being physically alone, but being alone and separate comfortably, i.e., while maintaining a sense of ego-relatedness. He took this ability as a measure of the stability and positive nature of one's internal object representations, as well as personal maturity and solid self-identity. He differentiated this sophisticated capacity from its precursor in childhood, in which a child is "alone in the presence of someone." He characterized the infant's experience of aloneness in the presence of someone in the following quotation:

When alone in the sense that I am using the term, and only when alone, the infant is able to do the equivalent of what in an adult would be called relaxing. The infant is able to become unintegrated, to flounder, to be in a state in which there is no orientation, to be able to exist for a time without being either a reactor to an external impingement or an active person with a direction of interest or movement. . . . In the course of time there arrives a sensation or an impulse. In this setting the sensation or impulse will feel real and be truly a personal experience. (Winnicott, 1958, p. 418)

Thus the "alone" experiences form the basis of the real self, while experiences in which the individual reacts and conforms to environmental impingement may be responsible for formation of the false self. The capacity to be alone for Winnicott, then, implies a comfortable acceptance of one's personal impulses and sensations; the capacity to be alone should correlate with a sense of self, which goes beyond a reactive or other-dictated definition of self. Winnicott stressed the paradox in which it is initially the reassuring presence of the caretaker which allows the infant comfort in experiencing his or her own sensations, his or her "aloneness."

Winnicott's understanding of the mature adult involved this "true self" conception. Yet, in contrast to modern American values and mythology, he made it clear that the valuable truly personal experiences are made possible by a deeply ingrained ego-relatedness. And just as the healthy individual has a capacity to accept his or her aloneness and differentness, she or he has a capacity for "mature dependence" in relationships. Thus the balance of relatedness with a sense of personal, nonreactive, separate self was crucial for Winnicott in an understanding of healthy maturity. This duality is to be distinguished from the American dream of independence and individualism, in which, for example, Thoreau is idealized and mythologized (inaccurately) as an emotionally and physically self-sufficient man (Edel, 1975).

Winnicott appears to have been aware of the problems inherent in the valuation of independence and individualism, which Philip Slater

(1970) has so effectively described. Probably Winnicott would have applauded Slater's thesis that modern American culture's overvaluation of individualism, privacy, and self-sufficiency has led to an increase in experiences of loneliness, isolation, boredom, and ironically an increase in uniformity and a decrease in a sense of safety (Slater, 1970). In arguing that the capacity to be alone is a psychological strength, Winnicott did not envision the current cultural fantasy of living alone in a cabin in the Vermont woods and providing for all one's own needs, in other words, a fantasy of total independence and self-sufficiency. He did not advocate "solo" wilderness experiences or romanticize the hermit's lifestyle. In fact, as is apparent, he understood an ability to enjoy solitude as a measure of "ego-relatedness." Clearly, a capacity to be alone, as Winnicott described it, is a mark of and perhaps a prerequisite for a capacity for intimacy. Relatedness to others allows comfort in being alone and vice versa; Winnicott points to the unity of the two concepts.

At about the same time that Winnicott was exploring this duality, Frieda Fromm-Reichmann was asking similar questions. In an unfinished article "On Loneliness" which was published after her death in 1957, Fromm-Reichmann began an exploration of loneliness, a task which she felt had been scrupulously avoided by authors of the psychiatric literature because of its anxiety-arousing impact. She noted that a great variety of distinguishable experiences including "aleness, isolation, loneliness in cultural groups, self-imposed aloneness, compulsory solitude and real loneliness" are lumped together as "loneliness." In specifically addressing the capacity to be alone she stated:

While all adults seem to be afraid of real loneliness,* fear of aloneness and tolerance for it vary from person to person. I have seen, for example, people who got deeply frightened facing the infinity of the desert with its connotations of loneliness, others who felt singularly peaceful and serene and pregnant with creative ideas when left alone with their oceanic feeling in the face of nature. I would like to . . . ask the reasons for the deep-rooted fear or anxiety connected with aloneness and the threat of ensuing loneliness that is felt by one group of people and the fearless enjoyment of it felt by others. Why are so many people afraid of temporary aloneness or even such experiences as mere silence, which may--or may not!--connote potential aloneness? (Fromm-Reichmann, 1959, pp. 328-329)

Thus, in the late 1950s, Fromm-Reichmann asked the question which is at the heart of this research endeavor: What determines the capacity to be alone comfortably? Fromm-Reichmann did not know whether or not the degree of tolerance of aloneness was related to "real loneliness," but she did frame a partial answer to the question. She felt that there is a general tendency to draw a "self-orientation," a sense of personal reality, from the interpersonal roles, relationships with, and feedback from others. Whether or not a person panics in the face of the possible loss of this orientation during aloneness depends, she said, on the "vicissitudes of personal development."

What Fromm-Reichmann meant by personality development is unclear. Perhaps she would have embraced Winnicott's and Guntrip's elaboration of the trait of ego-relatedness as a component of personality development. Guntrip discussed the concept as follows:

*In using "real loneliness," Fromm-Reichmann referred to the terrifying, uncommunicable experiences of unrelatedness suffered by schizophrenics, "in which the fact that there were people in one's past life is more or less forgotten and the hope that there may be interpersonal relationships in one's future life is out of the realm of expectation or imagination" (Fromm-Reichman, 1959, p. 327).

Ego-relatedness is a positive and persisting quality of the experience of the well-mothered infant, that he develops a growing sense of his own ego-wholeness and ego-identity, as a part of his overall experience of being in a reliable, secure, supportive relation to his mother. As this experience grows and becomes a permanent characteristic of his "self-feeling," he becomes able for longer and longer periods to be alone, i.e., to accept the physical absence of mother and of other people without anxiety or panic. He has grown to be an intrinsically ego-related child. His feeling about his enviroing world is positive and trustful, and when he is alone he does not feel isolated or mentally out of touch. (Guntrip, 1969, p. 221)

Guntrip suggested that "ego-unrelatedness," the lack of this related self-feeling, is the key to understanding all psychopathology. With extreme ego-unrelatedness, there is isolation, "a total absence of all object relationship internally" (1969, p. 225). In striking contrast to the comfort and enjoyment of being alone in the mature, ego-related person, the ego-unrelated person may feel separation anxiety, panic, a sense of extreme isolation, and even unreality. Primary ego-unrelatedness causes what Guntrip called "ego-weakness," at the root of severe disturbances involving regression and impaired adaptive functioning.

Object Relations Theory

Guntrip and Winnicott drew on tenets of a lively and growing literature of object relations theory in the work on the capacity to be alone. This literature, originating in Britain, includes such notable contributors as Fairbairn, Guntrip, as well as Winnicott. The work of Melanie Klein was later adopted by the object relations theorists. These four writers and other British and American authors disagree on

many important fronts. Furthermore, at times they do not even speak the same language and worse yet, they use the same words to denote entirely different meanings, leading to incredible confusion and blockage of communication. The common factors which hold the British school together as a configuration and object relations writings together as a general theory appear to be the following: focus on preoedipal development and related pathology, espousal of an "object-seeking" aspect to human nature, and postulation of an internal world of object and self-representations.

Premoral Development

First, object relations literature has expanded the traditional psychoanalytic understanding of development. Freud expounded the presence of oral, anal, and phallic stages of development within the first five years of life, but his clinical and theoretical emphasis certainly stressed the Oedipal period, with its three body relationships. While Freud did comment on early growth, his detailed contributions and clinical expertise concerned events which occurred between the ages of four and six, when the young child had some sense of him or herself, and of the mother and father as separate beings with conflicting wishes. Traditional psychoanalysis is designed for work with neurotic persons, that is, for individuals whose problems are Oedipal in nature and have by definition achieved a considerable degree of successful intrapsychic development. Patients with premoral pathology such as schizophrenics were not generally considered suitable candidates for psychoanalysis.

Object relations theorists, through their work with children and with more disturbed patients, have expanded the developmental theory by focusing on the events of the preoedipal period. Object relations theorists pay special attention to the first three years of life, and focus particularly on the initial all-important two-body relationship between the mothering one and the child. "Good enough mothering" during these first years seems to be considered the primary key to healthy psychological development, and the primitive fantasies and affects of the infant are explored in detail, as they are believed to maintain powerful influence in adult life, particularly in psychopathology. For example, omnipotent fantasies and separation anxiety are identified in normals and patients as having antecedents in infancy. As premoral pathology has become the focus of a great deal of recent clinical research, new treatment approaches are being developed in which psychoanalytic technique is adapted to the more severe ego disturbances involved in narcissistic, borderline, and schizophrenic disturbances. In addition, persons who would have been viewed as neurotics in the Freudian tradition are now undergoing analyses which aim beyond Oedipal resolution. Often Oedipal material is considered a smoke-screen for earlier conflicts, which are now being analyzed in persons who are in many ways well-adjusted and healthy. So preoedipal material is coming to the fore with clients too disturbed to have been analyzed in the past, as well as in the more typical patients entering psychoanalysis.

Jim Morrison, former lead singer of "The Doors," is believed to have suffered schizoid conflicts and committed a schizoid suicide

(Hopkins & Fine, 1977). When asked if his lyrics which tout Oedipal material might be a smokescreen for something else, Morrison responded with the following succinct and dramatic characterization of the new premoral focus of the object relations school.

I know what you're leading up to. The new orality stuff. I've read some of Melanie Klein and the others. The idea that the Oedipal layer isn't as deep as people used to think, that it gets deposited when the kid goes into the genital period and a whole lot of stuff has come together in his head before this, below it, when he was all mouth and no muscle or genitals . . . There was just oral passive helplessness and bawling for Big Ma before the kid began to grow muscles and came to see his genitals as muscle, and could counter his ache for Ma's shelter with a little genital aggression, at least in his fantasies. Deny yearning mouth with blustering phallus. I know this--there's a whiny toddler inside every growling rapist school.

Sure. By this reasoning it's easy to make a big red badge of your Oedipality and wear it on your sleeve. It's closer to the surface and you can dredge it out a lot faster than the worse Ma-cuddly stuff under it. Use the one to hide the other. . . . Cop out to the Oedipal sin because it's nowhere as bad as the oral ones that lie deeper. The crimes of the sucking babe wanting to hold tight to Mama and go on sucking forever and feeling abandoned by the old biddy because first she ejected him, then shoved him aside, cut him off. Anybody'd rather own up to fantasy crimes of muscle than those of blobby and flabby . . . (Wolfe, 1977, p. 184 as quoted by Hopkins & Fine, 1977)

This passage is included because in Morrison's to-the-point vernacular, he has correctly captured the essence and flavor of the object relations theorists' focus on earlier development, especially as Klein and Guntrip conceived it.

Humans as "Object Seekers"

A second characteristic of the object relations school is a general agreement on an "object-seeking" aspect of human nature which may be

observed within months of birth, if not from birth. While there is disagreement as to the presence and role of instincts among object relations theorists, there is at least a new recognition of the relational context in which the so-called instinctual urges occur and are satisfied or frustrated. Klein, a Freudian theorist who wrote in the thirties, forties, and fifties, stressed the impact of the inborn instincts, including the death instinct which has met with so little acceptance in the clinical community. She felt that the degree of pathology in an adult was often a direct function of the intensity of the instincts. To put it another way, she believed that an infant might be born with a greater than average quantity of aggressive instincts or death instincts, thus suffering a psychic defect from the start. Even with this philosophy, which differs from that of many current theorists, Klein's (1975) work was important to the object relations theorists because she related the infant's instinctual experience to his or her experiences with the mother, notably the feeding experience. Thus, she related an infant's persecutory anxiety to both the death instinct and to the experience of the unsatisfying "bad breast" onto which the instinct is projected. The idealized "good breast" is likewise the repository of "love impulses." The baby, initially "all mouth," expresses the instincts and forms the instinctual fantasies in the context of the mothering environment, a context which Klein examined carefully. This recognition provides an aspect of common ground even with Fairbairn, who stood as a revolutionary at the far left of the spectrum of opinions on the subject of instincts, in spite of his conservatism as a clinician.

Fairbairn (1963) proposed that it is the ego which is present at birth, rather than the id. Fairbairn denied the existence of a death instinct, and saw aggression as a reaction to environmental frustration or deprivation. He conceived of the libido as an object-seeking force. He seems to build on some of Klein's observations, however, in his formulation of the libidinal and antilibidinal ego structures based on the infant's internalizations of the exciting and rejecting objects, respectively. Thus, theorists quite far apart in their understanding of instincts, are zeroing in on the early relationship matrix and using the assumption that humans seek relationships from the beginning.

Internal Object Representations

The third general descriptor of the object relations school is its identification of a very real internal world of relationships as well as an external world. Authors disagree on how and why the internal world of representations of "self" and "others" comes to develop in infancy, but they are in agreement in their observation that conscious and unconscious representations of early relationships affect adult relationships. The object relations group holds that intrapsychic structures, i.e., internal representations developed in early life, act as a model and perceptual filter in future relationships. The internal representations are based on actual experiences in early relationships, but fantasy, and for some authors, instinctual processes, also play a role in the formation of these structures. The nature of the internal objects develops and changes during infancy and

childhood as cognitive and locomotor abilities allow, and as the environment permits. Many analysts of the object relations school rely heavily on the reconstruction of the patient's early years, with foci on possible disruptions in the separation-individuation and internalization processes. This is because of the belief that problems in adult relationships and self-concept are based on the filtering internal representations composed of archaic images formed in infancy.

Terminology

A brief exploration of some of the object relations school terminology with regard to the internal world may be helpful. First of all, "object" was a term originated in 1915 by Freud (1957) to denote anything towards which instincts are directed. In the object relations framework, objects are ordinarily people, certain aspects of people, or symbolic images of people. The term "object" has been used confusingly to refer both to internal representations and to actual persons in the external world. Inanimate subjects such as the baby's favorite blanket can be considered "transitional objects" (Winnicott, 1953) as they are the objects of love and hate and as they serve symbolic functions. An object relationship usually refers to more than a person's style of interactions with real people in the environment, but includes the manner of internal representation of the objects and the manner in which the objects shape the subject's environment (personal communication with Jack Barlow, April 4, 1981). Schafer (1968) noted that object representations include somatic, affective, diffuse experiences

and preverbal conceptualizations; they are more than a simple mental image or idea. Schafer defined internalization as "those processes by which the subject transforms real or imagined regulatory interactions with his environment, and real or imagined characteristics of his environment, into inner regulations and characteristics" (Schafer, 1968, p. 9). Laing (1967) defined the transfer from "outer to inner" worlds as a change "from one modality of experience to others: namely from perception to imagination, memory, dreams, fantasy" (p. 113). Laing wrote that it was not simply representations of the "self" and "other" which are internalized, but complex patterns of family interaction. Other authors such as Kernberg have focused on the idealized and "bad" self-objects and other-objects; in contrast, Fairbairn felt that it was only "bad" objects which were internalized.

Discussion of the theory and research concerning early development will shed more light on the relevancy of the object relations tenets to a discussion of the capacity to be alone.

CHAPTER 2

DEVELOPMENTAL ISSUES

In his article on the capacity to be alone, Winnicott stressed his view that the tolerance of aloneness is developed, ironically, in the presence of another, most usually the mother. He stated:

. . . we do need to be able to speak of an unsophisticated form of being alone, and that even if we agree that the capacity to be alone is a sophistication, the ability to be truly alone has as its basis the early experience of being alone in the presence of someone. Being alone in the presence of someone can take place at a very early stage, when the ego immaturity is naturally balanced by the ego-support from the mother. In the course of time the individual introjects the ego supportive mother and in this way becomes able to be alone without frequent reference to the mother or mother symbol. (Winnicott, 1958, p. 418)

The research of Mahler, Pine, and Bergman (1975) on the gradual processes of separation and individuation in the infant and young child supports Winnicott's statements. Extensive, long-term observations of normal children and their mothers led Mahler et al. to suggest stages of development by which the child achieves separation and individuation and comes to tolerate aloneness.

"Autistic" Phase

Mahler et al. reported that in the first few weeks after birth, the infant is in a "normal autistic phase." Mahler et al. concluded from their observations that in this first phase the infant uses an inborn stimulus barrier to protect itself from stressful stimulation. The baby has no awareness of the mothering agent as an agent with an

independent existence. Mahler's use of the term "autistic" seems an unfortunate choice, and her premise that early infancy is characterized by a lack of self-other differentiation has been questioned by other observational studies of infants. Nancy Davis (1980), for example, observed social responses in infants and found trends to suggest that a 2-3 week old infant can respond differently to mother versus stranger.

Symbiotic Phase

According to Mahler et al., it is with the dim realization that need satisfaction comes from the outside, that the infant enters the symbiotic phase. There is still very little differentiation; the infant sees the mother and the self as vaguely differentiated parts of one powerful unit (thus the metaphor "symbiosis"). The stimulus barrier becomes less necessary as the infant begins to rely on the hallucinated fusion of mother and infant for protection. Because the mother continues to be so active in the care of the infant, the infant's omnipotent fantasies are maintained and even enhanced. In these first phases of growth, the infant's immaturity is, as Winnicott noted, compensated for by the mother's support. Winnicott has underscored the unity of the relationship by the dramatic statement that there is no such thing as an infant without a mothering one (Winnicott, 1965).

Separation-Individuation Phase

As Mahler et al. described the third phase, separation-individuation, the slow and gradual process of developing the

capacity to be alone is clarified. The separation-individuation phase consists of two separate but intertwining tracks of intrapsychic development, which do not always progress evenly. Separation refers to the development of awareness of differences between self and others, and the growth of abilities to distance oneself, to form boundaries, to "disengage" from the mother. Individuation refers to the development of intrapsychic autonomy, memory, cognitive skills, reality testing (Mahler et al., 1975). As these tracks progress, the infant gradually develops a clear sense of his or her separateness from others and a sense of self or ego-identity. Gradually an internal world develops in addition to an external world. Eventually this world is peopled by whole stable internal object representations of the self and others. With this world, an individual is no longer truly isolated when alone; in a sense she/he has the "company" of the internal objects. All these factors are crucial to the capacity to be alone and are determined to a great extent by the process of separation and individuation occurring from about the fourth month through the end of the third year.

Mahler et al. (1975) noted four subphases in the separation-individuation process: differentiation, practicing, rapprochement, and the beginnings of individuation and object constancy. The focus of the differentiation subphase (beginning in the fourth or fifth month) is what Mahler et al. termed perceptual "hatching": a new alertness which accompanies a push towards sensory exploration of the environment. There is the beginning of the recognition of the mother,

indicated by the specific smiling response, stranger reactions (often a mixture of fear and curiosity), and a pattern of "checking back to mother" when exploring. McDevitt (1975) reported that the foundations of object constancy are forming in this subphase; there is a sense of object permanence (the child now knows to look for the hidden ball; she or he no longer believes it has disappeared into thin air when it is out of sight). At this point there is a diffuse memory of the mother which depends somewhat on the infant's need states. At this time internal objects are very unstable and fail to sustain the infant in the mother's absence. In the differentiation subphase, the infant can cope with the distress in only two ways: either by accepting a mother substitute or by withdrawing regressively to a feeling of "oneness" with the mother. Transitional objects or soothing gestures reminiscent of the mother often are seen during this phase. Transitional objects, extensively discussed by Winnicott (1953), represent an intermediate stage in the development of internal objects. The transitional object, such as the favorite, constantly cuddled blanket, symbolizes the mother and comforts the infant when the mother is unavailable. Later on in the child's life, the external symbolic object becomes unnecessary as the internal representation of the mother is developed.

The practicing subphase, which begins when the infant is seven to ten months old, is characterized by the child's increased mobility. Early practicing occurs with the advent of crawling, climbing, holding on upright; the phase of practicing proper coincides with the ability to

walk. As the motoric capacities increase, several changes occur. First, a great deal of exploration is made possible and in Greenacre's (1957) words, the child begins a "love affair with the world." The child is fascinated by the environment and highly invested in his or her developing motor skills. There is an imperviousness to hurts and frustrations during the practicing phase. Also, the child becomes more able to control his or her separations from the mother. Generally, he or she becomes more able to play or explore alone and seems less aware of the mother's presence. An "optimal distance" from the mother is discovered by the mother and child, although the child returns to the mother frequently for the "emotional refueling" of physical contact. Splitting of the mother into part-images occurs (good symbiotic mother, bad separating mother), and "low-keyed" moods are observed in the children when the mothers are out of the room. McDevitt (1975) noted that the infant has developed "a more differentiated image of his mother, which comes to mind whenever he is reminded of her or needs her" (p. 722). This more stable image, along with the tendency to cope via active mastery, allow the toddler to deal more readily with brief absences, especially as she/he begins to imitate the mother in symbolic play. McDevitt added, "In the practicing subphase, the infant seems to maintain an 'illusion' that his mother is with him or nearby whenever he chooses to move away from her, probably because self-object differentiation is still far from complete" (McDevitt, p. 727).

As the child develops a still further understanding of his/her separateness from the mother, the rapprochement phase begins, coming to a crisis period at 18-21 months. At this point, the notion of omnipotence is lost; the child learns that she/he is physically separate from the mother and is in fact very small, weak, and helpless. When she/he is alone, there is no longer the illusion of the mother's presence; there is a new awareness of being all alone. Suddenly, the child once again becomes very aware of the mother's whereabouts. Renewed stranger anxiety and "shadowing and darting away" are observed in this period; the child may either shadow the mother constantly or come up to her and "dart away" with the expectation that she chase him/her and sweep the child off his or her feet. When these behaviors continue with intensity, when separation anxieties are greater than average, when excessive sleep disturbances occur, especially beyond the second year, the child is having considerable trouble resolving the rapprochement crisis. Mahler et al. (1975) considered these evidences of discomfort with aloneness as potential "danger signals" for the child.

Again, an "optimal distance" must be found for the mother and child. Development of language may help to increase this distance and to increase the availability of other relationships (especially with the father). During rapprochement Mahler et al. observed great "ambitendency" towards the mother; the child alternately clings to her and pushes her away. McDevitt suggested that the fear of object loss is now combined with a fear of the loss of the object's love. Simultaneously, however, there appear the heightened anger and aggression

(perhaps related to the feeling of helplessness which replaces omnipotent fantasies) which are directed towards (and projected onto) the mother (McDevitt, 1975). Thus, the child is torn between a desire for closeness and approval, and a push for independence. Wagner and Fine (1978) suggested that the child's increased anger "interferes with the capability to maintain a sense of the good internal object image during the mother's absence, so that the serene state of mind implied in the capacity to be alone (Winnicott) is frequently not attainable" (p. 11). McDevitt's observation of an inverse relationship between hostile aggression against the mother and the child's capacity to enjoy playing on its own supports this suggestion. Hostility at this point seems to lead to the child's clinging rather than to autonomy. Thus the mother's response to anger is important, particularly her ability to accept reparation from the child. Winnicott noted that the mother's unperturbed survival of the child's rageful fantasies is crucial to the development of reality-testing.

The fourth subphase, labelled "Consolidation of Individuality and the Beginnings of Emotional Object Constancy" occurs from 24-36 months. As the title of this subphase implies, the processes put in motion during this subphase (the definition of individuality and the achievement of emotional object constancy) continue to be relevant throughout adult life. The achievement of object constancy in this subphase goes beyond the cognitive ability to recognize that objects are permanent; it involves the formation of whole internal objects. The mother, who was formerly represented internally by good and bad

part-objects, is now accessible to the child as a stable, whole object with both good and bad qualities. With such an internalization, the child no longer hates the mother just because she is absent. Instead she/he can keep a largely positive image of the mother and feel more comfortable being alone. According to McDevitt, identification with the parents plays an important role in the development of stable object representations; by "playing the role of mother, the child builds and reinforces the internal object" (pp. 733-736). In this phase, there is growing tolerance of separation as individuation and object constancy develop. Even so, a traumatic episode such as the birth of a sibling may disrupt the image of the mother. It is important to note, as various researchers have, that the more stable and benign the environment has been for the child, the better the child is able to internalize stable, trusted objects, and the more easily she/he is able to tolerate aloneness. Mahler et al. also described the development of purposeful play, a sense of time (and growing abilities to delay gratification and to be alone), negativism, and more complex cognitive functions during this phase, all of which add to the child's ability to be separate.

Thus far, the findings of Mahler et al. and McDevitt have been used to illustrate and support Winnicott's conclusion that the capacity to be alone develops paradoxically within a dyadic relationship, in which the mothering one's ego-support is eventually internalized by the young child. If the mother has been a "good-enough-mother" and has maintained an adjusting "optimal distance" from the child, emotional object constancy develops.

To summarize, the capacity to be alone is a sign of emotional maturity which is developed in the presence of the mother. During the subphases of separation-individuation, there develops a recognition of separateness, an object constancy, and eventually, a means of integrating intensely ambivalent feelings. With the ability to form a stable, whole internal representation of the mother which unifies the aggressively and libidinally cathected part-objects, there is a capacity to be alone. In solitude, this internal object can be referred to for reassurance, instead of the actual mother or transitional object. Also, a stable representation of the self forms, which adds solidity and reality to the experience of being alone. These object representations of the self and others are accompanied by a sense of ego-relatedness, of security, trust, and belongingness to the external environment. Without whole internal objects and ego-relatedness, there is failure to develop the capacity to be alone.

CHAPTER 3

DISCOMFORT IN ALONENESS

What are the factors which make a person experience time alone as uncomfortable? What is the answer to Freida Fromm-Reichmann's puzzle: time alone is for some the optimal condition for the most creative, productive, enjoyable experiences; for others it is a distressing experience to be avoided? Various authors have suggested that the fear of aloneness occurs in many relatively normal humans, and is not simply a sign of psychopathology. Pascal made the sweeping statement, "I have discovered that all the unhappiness of men arises from one single fact, that they cannot stay quietly in their own chambers" (Pascal as quoted, 1950). His belief is that dislike of or restlessness when alone is a universal human quirk leading to all sorts of problems. Freud suggested a similar notion in 1919. While Freud did not develop a consistent understanding of intolerance of aloneness, he commented in 1919 that the "uncanny" effect of silence, darkness and solitude produce "infantile anxiety from which the majority of human beings have never become quite free" (Freud, 1963, p. 252). Adults retain the preverbal experiences of helplessness and fear that accompanied their alone experiences as infants. Here Freud seems to point to the universal experience of separation as the cause of commonly experienced discomfort in aloneness or in conditions suggestive of aloneness.

According to Mahler et al., an infant is not really aware of his or her aloneness. Initially there is no comprehension of the self as

distinct from the mothering one, no ability to distinguish internal impulses from external events. An infant's survival is totally dependent upon the actions of caretakers; even a few hours of isolation will result in hunger and discomfort for the infant. However, it is not until there is some understanding of separateness and a concomitant comprehension of dependence, that a toddler recognizes aloneness and responds to it with terror. The infantile anxiety to which Freud referred would more correctly be called separation anxiety. It is not unnatural that early experiences, often only partially verbal, continue to haunt adults, distorting perceptions of aloneness in times of stress, particularly when dependency issues are aroused.

Mahler's research on the separation-individuation process and Winnicott's theoretical notes on the development of the capacity to be alone lead to the hypothesis that events in the mother-child relationship during the separation-individuation phase affect the adult's comfort or discomfort with aloneness. Specifically, the development of constant, sustaining, whole internal objects is believed to be a critical factor in the adult's ability to find comfort in solitude. Recently a flood of theoretical and clinical material has connected early developmental problems in achieving these internalizations with borderline, schizoid, and narcissistic pathologies in which intolerance of aloneness is often described. At the same time, it is recognized that a healthy adult may experience discomfort in aloneness at times for a variety of reasons.

Childhood experiences and needs do continue to color even a healthy adult's perceptions of aloneness. It is not uncommon for an adult in bereavement to experience a paralyzing fear of aloneness in which dependency needs are exaggerated to the point that they resemble the perceptions of a very young child. When the bereaved wife says, "Without my husband, I will die," she is probably operating under the influence of potent childhood memories in which aloneness was genuinely life-threatening.

Sullivan (1953) described a series of developmental interpersonal needs in childhood, which result in different types of loneliness. His view is that an infant needs tenderness, exemplified in physical contact. In childhood, Sullivan continued, there is a need for an adult audience. The juvenile requires the presence of "compeers" with which to share play and to receive acceptance. According to Sullivan, it is not until preadolescence (around eight and one-half to ten years) that the child develops a need for a "chum" and loneliness is experienced as a lack of an intimate exchange. Sullivan has given us clues as to possible components of experiences of uncomfortable aloneness in childhood and in adulthood in terms of failures to meet the needs he described.

Very often it seems that the term "lonely" is used to describe the experience of missing a particular person: a "chum," lover, or family member. This type of discomfort reflects a relatively mature need within Sullivan's schema. At this point in development identity is established to a fair degree and there is appreciation of others as

unique beings and of relationships as positive exchanges. More primitive interpersonal needs involve the definition of self through the reflections of others. A normal adult hones self-identity through contact with and feedback from others; at times she or he may even rely exclusively on others for accurate self-perceptions. For a healthy and mature adult, group associations, approval from peers and authorities, and roles defined by others contribute to a sense of self.

At this point, it will be useful to turn to some of the theory and research based on psychotherapy patients. Narcissistic and borderline patients sometimes present complaints of a constant fear of aloneness and frantic avoidance of physical aloneness. Clinicians also report a related phenomenon: the intense loneliness and longing for contact that such patients report.

Adler and Buie (1979) have spoken specifically of the problem of aloneness for borderline patients in an important paper. They explained some of the reasons that the Diagnostic and Statistical Manual of Mental Disorders III, Kernberg (1975), Mahler (1971), and many other authors have associated borderline pathologies with painful experiences of aloneness characterized by panic, emptiness, and/or despair. Adler and Buie defined borderline patients as persons with stable personality organizations who experience "intense needs to be held, fed, touched, and ultimately to be merged together" (1979, p. 84) in dyadic relationships, who are especially vulnerable to feelings of abandonment and fears of aloneness. Consequently borderline patients are frequently overwhelmed by rage when the people they

need so desperately disappoint them by being unwilling or unable to fulfill their needs. Their hypersensitivity to abandonment and their intense rage in its face lead to myriad problems in relationships, defended against by primitive methods which often compound the problem of aloneness. That is, projection, projective identification, splitting, and primitive idealization distort perceptions of significant others, such that relationships are viewed as threatening, or at best, chaotic and unrealistic.

Adler and Buie reported, "A notable aspect of the borderline patient's experience with aloneness is his relative or total inability to maintain positive fantasies or images of sustaining people in his present or past life" (Adler & Buie, 1979, p. 83). There are several reasons for this. First, the rage which is experienced when others disappoint the need for fusion can be extreme, to the extent that the representation of the other is annihilated. Adler and Buie referred to a patient who said he "stomped" the therapist from his mind. Second, because there is fear of being engulfed or engulfing the other, there is a defensive avoidance of intimacy, which in turn leaves the borderline individual needy, alone, and with little in reality from which to form an image of a sustaining other. Third, Adler and Buie postulated that the borderline internal representations are made unavailable because his/her need to deny grief in the face of object loss. The defensive denial amounts to a philosophy that it is better to be without loved ones than to deal with losing them. A fourth reason for the intolerance of aloneness seen in borderlines, the paper continued,

involves the failure or partial failure of the borderline individual to develop evocative memory for sustaining objects. Thus, the patients described earlier may not have been able to draw on any mental images of themselves or others when alone.

While Adler and Buie were addressing borderline pathology in their article, it is not difficult to apply their ideas to the experiences of more healthy individuals. One might postulate that a healthy adult might have difficulty with aloneness under certain circumstances. At times, a normal adult may encounter situations which provoke rage, the fear of engulfment or becoming engulfing, and/or the feeling of vulnerability to object loss. Although these situations would occur less frequently and with a less intense and lasting reaction than they would for a borderline patient, they could result in a temporary disturbance in the internal object world which could lead to discomfort in aloneness.

In explaining the concept of evocative memory, the authors referred to Piaget's work on the development of mental representations. In 1937 Piaget described how at 5-8 months of age a baby will not look for a toy placed behind a screen even if the baby watches the placement of the object. There is apparently no memory for the toy when it is out of sight. At 8-13 months, a baby develops a capacity to remember a toy for a few seconds and it will look for a hidden object if it has seen where it has been hidden. At 13-18 months the child will pursue a toy that has been transferred from one hiding place to another as long as the child has seen the movement. It is not until

18 months of age that a child will keep looking for a toy when she/he has not seen the second hiding. It is not until this point that the mental representation has a degree of permanence in the child's mind. Fraiberg (1969) has described this stage as representing the capacity for evocative memory, in which a toddler can call up a mental image without aid and without the stimulation of a need state. Fraiberg contrasted this ability with the recognition memory demonstrated at the earlier stages in which the child can remember an object for only a few seconds but will not look for it if she or he has not viewed the hiding.

Bell (1970) found that "person permanence" will develop before "object" permanence (i.e., for a toy) when the mothering appeared more positive. However, memory for a toy will develop first when the mother appeared rejecting. In addition, the more positive maternal experience fostered earlier development of both person and "object" permanence. This suggests that there can be problems with affective object representations when no difficulties are apparent in cognitive development. And, as Fraiberg (1969) reported is the case in blind infants, object constancy for persons can develop normally although memory for objects such as toys may be retarded.

Adler and Buie (1979) postulated that the capacity to evoke an image of a sustaining other (affective object permanence) is crucial to the development of a capacity to be alone. They hypothesized that disturbances in the holding environment provided by the mother in the first two years of life may leave a child prone to a loss of the

evocative memory of the mother. The authors noted that the absence of a sustaining object or affective memory of it leads to terror in aloneness as it calls up the infant's experience of aloneness, in which psychic and physical survival are at stake.

Borderline adults, then, the authors proposed, have not achieved "solid evocative memory in the area of affective object relationships and are prone to regress in the area of object relations to recognition memory or earlier when faced with certain stresses" (Adler & Buie, 1979, p. 87). This would explain why a borderline patient is so traumatized by aloneness, by a therapist's vacation or other brief separation. It shows why there is the tendency (described by Modell, 1963) for borderline adults to use transitional objects as concrete aids in the evocation of the memory of the therapist, just as a child uses a blanket or teddy bear to provide soothing in place of the mother before the capacity for evocative memory is fully developed.

The concept of evocative memory is related to the notion of object constancy. Object constancy requires the ability to perceive people as having a "permanent" existence whether or not they are immediately visible. Furthermore, Mahler et al. (1975) used the term to describe an affective sense of constancy in which the image of the mothering one remains affectively positive, although there is recognition that the "good mother" and the "bad mother" are the same person. Mahler et al. stressed that there are degrees in the attainment of object constancy and its development is in fact a life-long task.

In an unpublished paper by Cohen and Rasch (1979), object constancy is viewed as a protective illusion which defends most

"healthy" individuals from terror in aloneness. This is a concept similar to Masserman's (1956) description of "necessary delusions." The borderline patient has failed to develop the illusion that people are permanent fixtures and can be counted upon not to die or become angry and rejecting during an absence, or that people are good and generally trustworthy. Thus, when alone, the borderline patient experiences great fear of abandonment and is compulsively drawn to people, although he or she is never really with people. Anything short of fusion is perceived by the borderline as evidence for total rejection, cruel abandonment, and inescapable aloneness. As Fromm-Reichmann explained, the aloneness is seen as permanent, similar to the young child's time sense in which "Now is forever" (Fromm-Reichmann, 1959). Cohen and Rasch described the borderline patient's tendencies to create "do or die crises" and to adjust chameleon-like to the environment as means of coping with the intolerance of anxiety and the fear of abandonment.

Perhaps the auditory and visual hallucinations which often accompany schizophrenia serve a defensive function against the terrifying experience of aloneness. Clearly the issue is complex; schizophrenics tend to choose social withdrawal at the same time that their fantasy life becomes more important to them and in fact more intrusive, often taking the place of interactions with the external environment. It is paradoxical, to say the least, that an individual who should theoretically be unable to tolerate physical aloneness in fact chooses aloneness whenever possible. Shein (1974) stated that

the schizophrenic's experience is that only she/he truly exists and "all others are affectively shadowy, ghost-like figures with no real life separate from his own concerns" (Shein, 1974, p. 98). Shein felt there is often a denial of profoundly painful isolation and loneliness in schizophrenics which affords the withdrawal. Thus for those with the absolute minimum of ego-relatedness, there may be a paradoxical seeking of aloneness due to the denial. Other authors have suggested that the awareness of one's real impulses, as occurs most readily when one is alone, may be intolerable to the schizophrenic, leading both to discomfort in aloneness and to hallucinatory defenses which ironically lead to increased isolation. Hallucinations and delusions of persecution or omnipotent control allow the illusion that one is not vulnerable to being left alone even if one chooses increasing social isolation.

Ivri Kumin (1978) discussed the complaint of emptiness as indicative of the type of ego structure present. He observed that the complaint of emptiness in less severely disturbed patients tended to be partial, symbolic experiences of emptiness often related to Oedipal fantasies. For the more disturbed patients, the experience of emptiness may be complete, total, somatically and concretely experienced and related to schizoid fantasies. Kumin related the risk of complete emptiness with part object relationships and said, "For these individuals the object seems too vital and too consuming. In relation to the object they feel swallowed up, smothered, or drowned; feelings related to fears of annihilation of the self or defenses against oral sadism" (Kumin, 1978, p. 209). Kumin noted that the incapacity to be alone

in schizoid and narcissistic individuals is related to incomplete differentiation between self and object representations and to an "empty ego core." For the schizoid patient, the ego core is "under-structuralized" and the periphery of the ego, the "shell," is "over-structuralized" via rigid defenses. Thus the schizoid individual often resists the formation of relationships, simultaneously complaining of intense inner emptiness. For the schizoid person, a sense of identity is based in a large part on the "primitive identifications with the original symbiotic object." According to Kumin, the tendency for schizoid individuals to seek reassurance of existence through reflections "symbolically in mirrors, narcissistically in the tribute and attention paid to him by others, and defensively in the conforming mirroring attitudes" (p. 208) is a search for a sense of self in which the reflection may symbolize the symbiotic mother. Masterson and Rinsley (1975) hypothesized that it is the withdrawal of the mother during the rapprochement subphase which leads to this damage to a sense of self.

Wexler and Steidl (1978), in a paper entitled "Marriage and the Capacity to Be Alone," concluded that a capacity to tolerate aloneness is essential in a healthy intimate relationship. They distinguished between mature empathy and primitive empathy, in which there is fusion of identities and no sense of what feelings belong to whom. Mature empathy was described by Schafer in his description of "generative empathy":

Generative empathy is a sublimated creative act in personal relationships which combines the gratifications of

intimate union with the recognition and enhancement of separateness and personal development of both persons involved. Such identification as is involved differs from the identifications which permanently modify the ego, for optimally it remains segregated within the ego, suspendible and available for contemplation and reality testing. (Schafer, 1959, pp. 370-371)

Contrast this description with the early "empathic linkage" between mother and child, which the borderline adult strives to reachieve in an attempt at fusion with a marriage partner. As examples of fusion, Wexler and Steidl (1978) pointed out marriages in which there is no tolerance of differentness or disagreement, in which there is denial of separateness, and in which aloneness is not tolerated. In fused couples, the partner is seen as the center of the world, the one source from which all sustenance is forthcoming (or denied). There is likely to be much ambivalence about the partner when inevitable problems crop up. The partners have no faith in their capacity to care for themselves and feel desperately dependent on the spouse, so that there is often a desire to control the comings and goings of the spouse. "Utter dependency is interpreted as togetherness," the authors commented (p. 77). When the illusion of fusion is broken by disappointment or the surfacing of one partner's autonomy, the couple will either "narrow their transactions to hide the changes, or one will precipitate a crisis, and the work to unbind from fusion is underway" (p. 77). The couple may lead a dull, highly structured life in which interactions are narrowed to issues of child raising or spending, for example, until one partner may precipitate a crisis by asserting autonomy, threatening to leave, pursuing an affair, becoming explosive or suicidal, etc.

Wexler and Steidl related the capacity to be alone-yet-together in a marriage to early developmental experiences. They noted that separate-but-together relationships characterized by mature empathy must be preceded by infantile experiences of being cared for satisfactorily, in which the developing autonomy expressed in language and play is respected by the parents. Also required is what Winnicott (1965) has called the capacity for concern, which begins as the infant comes to see the mother as a separate entity who cannot know all his or her feelings and needs. This represents the beginning of ambivalence, and the infant comes to recognize both loving and hateful feelings towards the parent which originate in him or herself. With awareness of his or her own negative feeling, it becomes important for the child to have opportunities to offer reparation to the mother.

Wexler and Steidl added:

Having developed some capacity to care for himself (with the development of internal representation of the mother), to be concerned for his mother as a person in her own right, and to use his own mental imagery of her, he has achieved the capacity to be actually alone with no fear of losing the relationship with her. He is a separate person; his mother is a separate person. They can be together or apart, either physically or emotionally, but both can feel that they are persons in their own right while feeling that the other is important. (Wexler & Steidl, 1978, p. 76)

In a study of submariners' wives who became patients in an outpatient setting, Pearlman (1970) noted various responses of these women to the separations of their husbands. These women regularly experienced separations from their husbands which would last about three months, for a total of six to eight months per year, Pearlman

reported that all of the 485 patients studied experienced a psychological crisis at each separation, no matter how many times before they had endured it previously. Interestingly, Pearlman reported the same sequence of reactions that Bowlby (1969) described as separation anxiety in young children who were hospitalized. Pearlman found that the submariners' wives first made a protest against acceptance of the separations: "Why does he really have to go?" Following this tension was a period of tearfulness and despair, expressed as "I'll never live through the next three months without him." Finally, there was a detachment which allowed a return to normal functioning, but was clearly a defense against the loss of the husband: "I don't care if he never comes back." Reunion with the husband was marked by anger and a desire to punish the husband for leaving, transient disorganization, and readjustments, just as observers have noted in young children reuniting with their mothers.

Pearlman reported that the most seriously disturbed group of eight patients responded to the separations with severe decompensations, despair, suicide attempts, alcohol abuse, and frenetic social activity. As might be predicted by current theory on the capacity to be alone, these patients revealed histories of prolonged symbiotic ties with one parent, often accompanying the loss of one parent before age three. Pearlman felt that parental intrusiveness was the more important factor than deprivation of parental love, because he found that in cases where there was no loss, marital discord or immaturity of a parent led to prolonged symbiotic attachment with one parent. The

relationships of these wives with their husbands tended to be symbiotic or fused, to use Wexler and Steidl's terminology. The presence of the husband was essential to therapeutic progress, Pearlman reported, for this group of patients.

In contrast to the disturbed group of patients, Pearlman described the majority of patients as tolerating separation fairly well, but reported failures to develop mature relationships with their husbands in the context of the disruptions. The typical woman in this group described herself as a love slave, "helpless to prevent domination and exploitation by an overpowering man, who would leave her instantly if she uttered a peep of protest" (p. 949). Signs of attempts to achieve fusion are evident in these women's characterizations of the good wife as one who never disagrees with her husband. Pearlman noted that the frequent separations allowed persistence of Oedipal fantasies and distortions in the perceptions of the husbands, exaggerated these women's fears of the effects of their own rage, and increased their fear of abandonment by their husbands.

Pearlman's belief that it was prolonged symbiotic ties to parental figures which led to the pathology noted in the most disturbed group of patients calls to mind Masterson's theoretical and clinical discussion of the etiology of borderline pathology. Masterson stated that borderline patients do not complete the normal ego development of the separation-individuation phase because the mother fosters the continuation of the symbiotic union (Masterson, 1976). Regressive, clinging behavior is reinforced; individuation is met with criticism or

withdrawal. Masterson and Pearlman offered evidence that the incapacity to tolerate aloneness is caused by parents who foster this symbiotic relationship, rather than the unavailable, inadequate parental environment which Guntrip suggested as the basis for these disturbances. They argued that over-parenting rather than deprivation forms the basis for these fragile egos. It is likely either extreme results in problems tolerating aloneness, as either event would result in feelings that the true self is unacceptable and should be repressed. Distortions of internal representations and failures to develop a sense of ego-relatedness are likely to result.

Alice Miller (1981) suggested in her book, Prisoners of Childhood, that gifted children are vulnerable to the often crippling pressures applied by narcissistically invested parents. These children may see only their achievements as valuable, and hold great contempt for their lonely, angry "true selves," and experience much shame and guilt. Miller reported:

The narcissistically disturbed patient did not have a self-object at his disposal during the symbiotic phase, nor a "usable" object in Winnicott's senses (1971)--one that would have survived its own destruction. Both the depressive and the grandiose person deny this reality completely by living as though the availability of the self-object could still be salvaged: the grandiose person through the illusion of achievement, and the depressive through his constant fear of losing the self-object. Neither of them can accept the truth that this loss or this unavailability has already happened in the past, and that no effort whatsoever can ever change this fact. (p. 63)

According to Miller, it is the narcissism of the parents which denies the needed self-object for this child, who in turn develops narcissistic disturbances.

To briefly summarize, discomfort in aloneness is not experienced exclusively by the severely disturbed. However, experiences of aloneness characterized by panic, total somatically experienced emptiness, depersonalization or derealization, uncommunicable loneliness believed to be permanent, and lack of evocative memory for sustaining others have been associated with schizophrenia and serious schizoid, borderline, and narcissistic pathologies. The etiology of these disturbances has been related to the maternal relationship within the first three years, and a defect of ego-weakness stemming from problematic distances fostered by the mothering one. One would expect that differences in mothering account to some extent for differences in tolerance of aloneness. As Winnicott's term "good-enough mothering" implies, child-rearing is a complex, demanding endeavor in which a wide range of acceptable behavior may produce children who grow to be healthy adults.

CHAPTER 4

RESEARCH ON LONELINESS

Few researchers have studied tolerance of aloneness or reactions to physical aloneness. However, there is a newly growing literature on loneliness, which seems relevant to a study of aloneness. Weiss (1973), a pioneer in loneliness research, defined loneliness simply as an absence of an emotional attachment or social network. Many of the other researchers are defining the subject area not in terms of actual aloneness, but in terms of the subjective, distressing perception that relationships are inadequate. In other words, loneliness is the cognitive discrepancy between what one views as optimal levels of social interaction and one's evaluation of one's social relations (Peplau & Perlman, 1982, Sermat, 1978). Thus, the discrepancy might be affected by cultural and personal expectations, as well as actual deficiencies.

Rubenstein and Shaver (1982) described a study in which phenomenological interview data with 50 adult Americans, as well as surveys of college students, provided the basis for composing a questionnaire about loneliness. The questionnaire was published in six American newspapers; 3500 of the responses were studied from New York City and Worcester, Massachusetts. Factor analyses suggested four types of feelings associated with loneliness: desperation, depression, impatient boredom, and self-deprecation. Adjectives are presented in Table 1 (p. 212). Five factors described reasons given for being

Table 1

Factor Analysis of Feelings When Lonely (Rubenstein & Shaver, 1982, p. 212)

Factor 1: Desperation	Factor 2: Depression	Factor 3: Impatient boredom	Factor 4: Self-deprecation
Desperate Panicked Helpless Afraid Without hope Abandoned Vulnerable	Sad Depressed Empty Isolated Sorry for self Melancholy Alienated Longing to be with one special person	Impatient Bored Desire to be elsewhere Uneasy Angry Unable to concentrate	Unattractive Down on self Stupid Ashamed Insecure

lonely: being unattached, alienation, being alone, forced isolation, and dislocation. See Table 2 for specific items. The most common behavioral reactions to loneliness were reading, listening to music, and calling a friend. Factor analysis suggested four factors in the responses to loneliness: sad passivity, active solitude, spending money, and social contact. See Table 3 for specific items.

Table 2

Factor Analysis of Reasons for Being Lonely (Rubenstein & Shaver, 1982, p. 213)

Factor 1: Being unattached	Factor 2: Alienation	Factor 3: Being alone	Factor 4: Forced isolation	Factor 5: Dislocation
Having no spouse Having no sexual partner Breaking up with spouse or lover	Feeling different Being mis- understood Not being needed Having no close friends	Coming home to an empty house Being alone	Being housebound Being hospital- ized Having no trans- portation	Being far from home In new job or school Moving too often Traveling often

Table 3

Factor Analysis of Responses to Loneliness (Rubenstein & Shaver, 1982, p. 215)

Factor 1: Sad passivity	Factor 2: Active solitude	Factor 3: Spending money	Factor 4: Social contact
Cry	Study or work	Spend money	Call a friend
Sleep	Write	Go shopping	Visit someone
Sit and think	Listen to music		
Do nothing	Exercise		
Overeat	Walk		
Take tranquilizers	Work on a hobby		
Watch television	Go to a movie		
Drink or get "stoned"	Read		
	Play music		

Rubenstein and Shaver noted that being alone is a common cause of loneliness for those who live alone, but they further explained that there are vastly different reactions to being alone:

Lonely people (i.e., those with high scores on the NYU Loneliness Scale) tend to associate negative feeling with being alone--when alone they feel afraid ($r = .41, .42$), anxious ($r = .48, .50$), and angry ($r = .51, .47$). In contrast, those who aren't often lonely think of solitude as a satisfying state. They feel calm ($r = -.34, -.38$), relaxed ($r = -.44, -.46$), creative ($r = -.34, -.38$), and happy ($r = -.60, -.57$). (p. 215)

(The two r values presented are from New York City and then from Worcester; correlation coefficients were all significant beyond the .001 level.) Rubenstein and Shaver (1982) hypothesized that both personality factors developed in childhood and recent adult experiences are responsible for the difference in tolerance of aloneness. For example, divorce of a subject's parents before the subject was 18 years of age seemed correlated with greater degrees of loneliness. Rubenstein and Shaver (1982) noted that although loneliness and depression are not equivalent, "it would be a mistake not to notice the well-worn path

from loneliness to depression" (p. 219). They found that the sad-passive style of response to loneliness (watching television, crying, overacting, drug use, sleep) was associated with self-deprecation and depression.

Michela, Peplau, and Weeks found that lonely people tend to attribute their loneliness to some unchangeable character defect, rather than an external factor or a factor which could be changed. Their unpublished manuscript "Perceived Dimensions and Consequences of Attributions for Loneliness" was cited by Peplau, Miceli, and Morasch (1982). Loneliness often seems associated with poor self-esteem, from this and other research.

Beck and Young (1978) differentiated between chronic loneliness, situational loneliness, and transient loneliness. Chronically lonely people, with dissatisfaction in their relationships existing two or more years, were described as having long-term behavioral deficits in relating to others. Situational loneliness was prompted by a specific crisis such as divorce. Transient loneliness, "everyday loneliness," involved occasional brief periods of loneliness.

Cutrona (1982) reported a study of the loneliness experiences of entering college students studied several times over their first year at school. She found that chronically lonely students (those lonely for the full school year) were likely to blame their own enduring traits for their loneliness, while transiently lonely persons pointed to a variety of both personal and situational reasons for their loneliness. Chronically lonely students seemed to have infrequent contact with friends.

Unlike the transiently lonely students who seemed to compensate for inadequate romantic relationships through friendships, those students lonely the full year felt that their loneliness could only be relieved by "finding a boyfriend or girlfriend," and were dissatisfied with friendships also. Cutrona described the lonely college student as unassertive, lacking self-confidence, highly sensitive to rejection, and having high expectations for his or her social life. Nevills (1978) similarly found that both circumstance and character factors contribute to the degree of loneliness experienced.

De Jong-Gierveld and Raadschelders (1982) in their study on types of loneliness drew on previous research to summarize three important dimensions of loneliness: (1) emotional characteristics of the loneliness experience, (2) type of deprivation (absence of an intimate attachment, feelings of emptiness, and feelings of abandonment) (3) time perspective (unchangeable, temporary, or unchangeable and caused by others). The authors studied questionnaire and interview data of 656 randomly selected Dutch respondents. They found four primary types of loneliness experiences: the "nonlonely"; the "hopelessly lonely who are very dissatisfied with their relationships," who may tend to blame others, feel empty, abandoned, and hopeless (14%); "the periodically and temporarily lonely" who are relatively socially active yet lack an intimate partner; and the "resigned, hopelessly lonely," often older widows, who view their relationship deficits as unavoidable.

Jones' (1982) review of research studying the social behavior of lonely people made the case that lonely people may develop patterns of interaction which increase their social marginality, and thus their loneliness. Jones cited Solano and Batten's 1979 unpublished manuscript "Loneliness and Objective Self-Disclosure in an Acquaintanceship Exercise." Solano and Batten found that lonely people self-disclosed more than usual in same sex dyads and disclosed less than usual in opposite sex dyads in a get-acquainted exercise. When Jones (1981) used a similar experimental format, he found that lonely people tended to rate their dyadic partners in the exercise more negatively, to be less attracted to them, and, to some extent, more inaccurate in assessing their partners' personalities. The partners did not rate lonely people differently from nonlonely people, but there was evidence that the lonely people perceived interactions differently. Goswick and Jones (1981) found greater self-focus in lonely college students, which made them less attentive to the feelings and needs of others. Jones (1982) stated,

. . . the reasons for loneliness are not to be found so much in the objective characteristics of the lonely person's social milieu (e.g., number of available friends or amount of social contact) as they are in the way in which lonely people perceive, evaluate, and respond to interpersonal reality. (p. 244)

Loneliness researchers continue to sort out definitions of loneliness among their subjects, as the experience seems to be highly individual. In addition, they are continuing to assess the role of actual isolation in the development of loneliness, along with personality

and situational factors. It seems that, especially among persons who complain of chronic loneliness, personality differences, differences in perceptions, and differences in expectations are evident. Loneliness researchers have not attempted, for the most part, to look for intrapsychic explanations for the differences noted; there is very little application of object relations theory, for example, to research findings.

CHAPTER 5

FORCED ISOLATION AND SOLITUDE

Written logs of experiences of prisoners kept in solitary confinement, of isolated explorers, and, to a lesser extent of those involved in sensory deprivation experiments, suggest that prolonged monotonous, forced aloneness seems to unleash a flood of fantasy material, some of it terrifying. Many of these reports described a struggle to remain "sane," i.e., capable of differentiating reality from fantasy and remaining in control of impulses.

Christopher Burney (1961), for example, in his report on his survival of an 18 month solitary confinement by Germans during World War II, described his systematic efforts to remain mentally healthy. He obsessively divided his days up by doling out the meager allotment of food at intervals over the whole day. He maintained attention to his appearance, manicuring himself with a splinter. He focused on the physical attributes of the cell and its furnishings, and found "company" in a snail which he kept in the cell. Despite his strategies to maintain reality testing and relatedness, Burney found that the solitude "weaned" him from the "habit of intercourse." In his first opportunities to communicate Burney was afraid that in speaking he would "show himself to be mad." The following statement is particularly interesting in light of confirmation by sensory deprivation experiments:

I soon learned that variety is not the spice but the very stuff of life. We need the constant ebb and flow of

wavelets of sensation, thought, perception, action and emotion, lapping on the shore of our consciousness now here, now there, keeping even our isolation in the ocean of reality. (p. 8).

Byrd wrote in 1938 as an explorer faced with visual isolation and monotony. He referred to a loneliness "too big" to dwell on safely. He explained that the monotony was nearly intolerable, "For where there is no change outside, men are driven deeper and deeper inside themselves" (p. 114).

Heron (1967) and others who have worked with sensory deprivation found the creation of fantasy images--often animals--was a frequent occurrence perceived as an attempt to reduce a growing sense of estrangement and unreality.

Suedfield (1982) expressed the belief that the disorientation, emotional reactions, hallucinations, and changes in body image which have been reported by solitary voyagers and prisoners are more a reaction to factors other than solitude itself. Often monotony, fear, illness, fatigue, deficient diet, and food or drug poisoning appear to account for the distressing symptoms. Suedfield argues that solitude is a valuable, positive experience, of importance in religious communion, rites of passage in many cultures, creativity, and personal growth. He states of positive experiences in solitude:

Aloneness in this context fills a need, removes a lack, impels growth. There seems to be no loneliness; rather the individual feels a freedom from distraction, from the usual restrictions imposed by social norms and the need to maintain face, and the benefits of reducing external stimulation to the point where the still, small voices can be heard. (Suedfield, 1982, p. 61)

Suedfield is a proponent of restricted environmental stimulation technique in which dark, silent immersion tanks are used to reduce stimulation. He views the technique as a therapeutic tool for a wide variety of difficulties.

Authors on the concept of privacy have concluded that voluntary aloneness is often a desired state which is a statement about the autonomy of the self (Laufer & Wolfe, 1977). Wolfe and Golan (1976) report that the institutionalized children will choose time in a seclusion room for privacy to good effect, preventing psychological withdrawal or acting out.

Few people have studied experiences of aloneness in healthy adults due to the difficulty of exploring the phenomenon. Direct or indirect observation of the behavior of a person who is alone, of course, distorts the experience entirely to the extent that the subject is no longer alone. Larson and Csikszentmihalyi (1978) bravely attempted to study time spent alone in adolescence through a random sampling of experiences. The authors used a remote control beeper worn by each of the 25 adolescents (13-18 years old) studied. When the beeper beeped at 5 to 7 random times between 8:00 a.m. and 11:00 p.m., the subjects were instructed to record their current activity, whether they were alone or not, their feelings about it, their involvement and motivation. In addition, scores on the Maddi Alienation Index were collected.

Larson and Csikszentmihalyi reported that in about a third of the times monitored, the adolescents were alone, most commonly engaged in

free-floating thought, passive entertainment other than watching T.V. (reading, listening to records or radio), sleeping and personal grooming. Times alone were more likely to be marked by reported moods of loneliness and hostility, weakness and passivity. The authors found that voluntary activities lead to more positive moods. During voluntary activities but not involuntary activities, moods are significantly more negative when alone than with others.

There were major differences between individuals in the amount of time spent alone. The authors found that the adolescents who spent the most time alone and those who spent no time alone were the most alienated, and those who spent "optimal intermediate amounts of time alone" were the least alienated. The authors commented on the paradox that aloneness, although experienced negatively, seems to have positive effects in moderation. They compare it to a bad-tasting medicine and suggest that aloneness is a valuable experience for adolescents in particular as it allows opportunities for integrative reflective activity, emotional release, rehearsal of "different selves," and greater opportunity for development of an autonomous identity.

In an informal study of solitary hikers on the Appalachian Trail, the author spoke to nine day hikers and backpackers about their experiences alone on two fall weekends. Interestingly, only the day hikers had chosen to hike alone for the sake of being alone; the backpackers (who were camping overnight for a week to months) reported that although they were comfortable hiking alone, they would have preferred to have a hiking companion but had been unable to arrange

vacation times, etc. to allow this. All the hikers interviewed spontaneously reported positive aspects of traveling alone in the mountains. Several mentioned that they perceived the time as a chance for problem-solving or abstract thought, and felt that their thinking was clearer as a result of being alone. Several mentioned an increased sensitivity to personal, internal rhythms, as well as an increased awareness of personal resources and self-reliance skills. Several mentioned feeling a part of nature in what was described at times as a religious experience. Some commented on a greater sense of freedom, in which greater focus was on the self, and paradoxically, a heightened awareness of the possibility of death, perceived as a growth experience. Two of the hikers commented that they felt that the aloneness increased the appreciation of friendship and intimacy. Although, of course, hiking in the mountains is a specific form of aloneness chosen for recreational and/or spiritual reasons and considered a positive experience to begin with, the hikers' responses suggest that the time spent alone was valuable to them in many ways by virtue of the aloneness.

CHAPTER 6

PURPOSE AND MEASURING TECHNIQUES

Purpose

Winnicott, Fromm-Reichmann, and Guntrip have spoken of a capacity to be alone as a mark of health in adolescence and adulthood. It appears that a capacity to remain relaxed and comfortable during a moderate amount of time spent in physical aloneness with a minimum of structure suggests a capacity for ego-relatedness, a characteristic which allows for concern and empathy. Many authors have asserted that the capacity to be alone is developed gradually in infancy and childhood as a function of "good-enough mothering," development of evocative memory for persons, development of solid, affectively integrated, constant internal representations, and development of an appreciation of boundaries between self and others. Problems in early development are hypothesized to be responsible for pathological syndromes associated with complaints of anxiety, emptiness, or restlessness accompanying aloneness. The inability to be alone comfortably, as it reflects ego-unrelatedness and immature internal object relations, is predictive of disturbed patterns of interpersonal relationships, in which mature empathy and lasting intimacy are unlikely to be achieved. Instead, chaotic relationships are the rule, characterized by the "in and out" pattern of avoidance of commitment, by fusion and symbiosis in relationships, and by tremendous fears of abandonment and rejection. Chronic loneliness may result from disappointments in

expectations for fusion and avoidance of intimate relationships. Generally, the capacity to be relaxed in aloneness appears to be taken as a mark of maturity and development of autonomy.

A wide range of functioning regarding this capacity is expected to be observable in a sample of outpatients of psychotherapy. Theory and research involving infant and early childhood development and the behavior of patients of psychotherapy lead to the following hypotheses:

1. Comfort in aloneness is most likely to occur with more structured activities. The less structured the activity engaged in, the more a person has to rely on internal resources. Aloneness is more likely to be uncomfortable as it is less structured and as it connotes being left or abandoned.

2. Greater degrees of development of internal object relationships should predict greater degrees of comfort in unstructured aloneness. Comfort in aloneness here is defined as an ability to tolerate moderate periods of relative physical isolation without anxiety, but not necessarily a preference for aloneness. The more comfortable in aloneness, the more stable, affectively integrated, and realistic will be the internal representations of self and others. There will be separateness from others implied in the more mature nature of the internal objects. Reported and inferred experiences of depersonalization, derealization, intense emptiness, fused relationships, and reliance on transitional objects are expected to be associated with a relative intolerance of aloneness, should they occur in the sample.

3. The more comfortable one is alone, the richer, more whole, and more accurate will be the evoked memories of early experience. Adler and Buie (1979) suggested that, at least in part, borderline pathology, especially panic in aloneness, is caused by a failure to develop evocative memory fully as a child. In adults, it is believed that the task of describing early memories, especially of the parents, should provide a measure of evocative memory in a non-need state. A continuum of skill in evocative memory is expected in an outpatient population, as is a range of abilities to tolerate aloneness. Those whose early memories are most rich, whole, and realistic are hypothesized to be most able to tolerate aloneness.

An additional purpose was to provide descriptive data on the nature of experiences of aloneness of an outpatient population. Types of discomfort and responses to discomfort were of special interest.

The factors requiring measurement to test these hypotheses are, obviously, very difficult to observe. The nature of object relationships is by definition an internal affair of which the subject is not fully aware. The capacity to be alone likewise is not possible to observe directly and must be inferred through indirect information.

In this study, dreams, early memories, and Object Relations Technique stories provided the projective data as a basis for inferences regarding the development of internal object representations. Initially it was planned to use Krohn and Mayman's (1974) scoring technique to score these three types of productions, but Object Relations Technique data were not well suited for the technique, and

additional sample scales were developed by the author for use with the ORT. Judgements on interview data in combination with therapists' judgements were used to select two groups: a group highly tolerant of physical aloneness and a group with low tolerance for physical aloneness. In comparing the two groups, it was expected that high tolerance subjects would obtain higher scores on development of internal object representations on dreams, early memories, and ORT stories than would low tolerance subjects.

Measuring the Level of Object Relationships

Early Memories

Alfred Adler was a pioneer in the use of earliest recollections as projective material. While Freud in 1917 (1963) commented on the concealing and disguising function of early memories as screens for earlier or more painful material, Adler stressed the revealing nature of early memories. He stated:

Out of the incalculable number of impressions which meet an individual, he chooses to remember only those which he feels, however darkly, to have a bearing on his situation. Thus his memories represent his "Story of My Life"; a story he repeats to himself to warn him or comfort him, to keep him concentrated on his goal, to prepare him, by means of past experiences, to meet the future with an already tested style of action. (1931, p. 73)

Thus memories, especially the earliest ones, reveal what Adler referred to as a person's "life-plan" and "life style," as well as possible reasons for the choice of such a plan. That is, the recollections reveal a person's interests, values, fears: the phenomenological

world, in short. Adler noted that earliest memories provide the most simply stated and important crystallizations of a person's dynamics and are usually offered without resistance. It was not relevant to Adler whether or not the memories had actually occurred as they were recalled. In both fantasied and "real" memories, there is a construction of a "life story," according to Adler.

Several researchers have validated the use of early recollections as a projective device particularly useful in a rapid screening assessment. Ferguson (1964) found that clinically trained Adlerian judges were quite consistent in their "life style summaries" written from a series of early recollections from 30 subjects. However, they could not make correct diagnoses at better than chance expectations. Both Adlerian and "eclectic" judges could match the summaries the three Adlerian judges had written to the correct records of early recollections. However, the Freudian judges found the task "incomprehensible," and were not successful in the matching task. Ferguson explained the lack of success of early memories as a diagnostic tool by noting the Adlerian notion that it is the interaction of life style and environmental circumstances which determines psychopathology, and not simply the life style alone.

In a comparable study, Lieberman (1957) found that reports written on the basis of a full battery of psychological tests and reports written on the basis of early recollections alone showed significant agreement, when scored via a checklist of personality traits. Lieberman used eleven psychotic and eleven nonpsychotic

subjects in this study, which supports the use of the early memory test as a rapid screening battery.

While most research into the use of the early memories test as a tool for diagnosis has met with limited success, some patterns have emerged. Jackson and Sechrest (1962) found support for the hypothesis that patients suffering anxiety will indicate early memories characterized by themes of fear, that depressed patients' memories will be colored by themes of abandonment, and that patients with stomach problems will produce memories concerning gastrointestinal distress. They also found that themes of sex were more frequent among obsessive-compulsives, and themes of accident, illness, and trauma were more frequent among anxiety neurotics, subjects suffering gastrointestinal distress, and normals.

Ansbacher (1947) reported research involving 271 male students in which themes reported in early memories were related to scores on a test of security (Mallow Security-Insecurity Test). While these two studies both indicate the validity of thematic interpretation of early memories, neither suggest that psychological diagnoses can be made accurately on the basis of early memories alone.

One good reason for including earliest memories in a diagnostic battery, however, lies in the fact that a subject's experiences immediately prior to testing are less likely to influence the memories than other projective material. Hedvig (1963) showed through experimentation that earliest memories are less likely to be affected by experiences of friendliness, hostility, success, and failure than are Thematic

Apperception Test stories. This has been used as an argument for the greater stability of early memories.

Mosak (1958) noted that early recollections are altered and refocused after a successful course of therapy, and has used them to determine a patient's readiness to terminate from therapy. So although early memories are relatively stable and likely to remain consistent through time, they also reflect changes in a person's internal world. Binder and Smokler (1980), Mosak (1958), and Kadis et al. (1952) cite examples of the usefulness of the early memories test in assessing and planning therapy.

The early memories test, then, seems particularly suited to an analysis of object relations development. Touted by Adler as an indicator of a person's life style, the test's usefulness has been validated in many ways and has been shown to be a relatively stable indicant of internal life.

Dreams

Dreams constitute another source of projective material also felt to be particularly germane to a study of object relations. Interpretation of dreams has long been considered a key to understanding both unconscious and phenomenological events, used as a tool in psychoanalysis as well as therapies developed by earlier and later psychologists and psychiatrists. Clearly dreams are not stable as are early recollections, but are influenced by daily events as well as long-standing dynamics. The idea of a projective analysis of manifest

dream content is not new, although researchers disagree about whether manifest dream content reflects degree or type of pathology. Although Mack (1967) found no differences between dreams of neurotics or normals and psychotics, Richardson and Moore (1963), Kant (1942), and Noble (1951) report that the dreams of schizophrenics often have a stark or bizarre quality which differentiates them from those of normals. Langs (1966) states that many qualities differentiate dreams of severe hysterics, paranoid schizophrenics, and psychotic depressives. Brenneis (1971) attempted to study ego boundaries and the type of thought disorder represented in the manifest dream. Brenneis found that schizophrenics showed less tendency to describe dreams in which they were a central figure, descriptions beginning with "I". He also found signs of thought disorder (fabulized combinations, confabulations, and contaminations) more frequently in the dreams of schizophrenics. According to Krohn and Mayman (1974), the reason for the limited positive findings of the study lies in its failure to make use of a "skilled clinician's empathic, intuitive sense of the primitiveness of the content of the dreams," relying instead on exclusively "formal, highly specific, concrete criteria in rating the dreams" (p. 447).

Object Relations Technique

In 1955, Herbert Phillipson, a British psychologist, developed the Object Relations Technique, a projective method for studying interpersonal relations. It is a test similar to the Thematic Apperception Test in which the subjects are instructed to tell stories about a series of

ambiguous pictures. The ORT pictures portray humans drawn so ambiguously that sex, movement in relation to each other, and facial expression must be projected onto the pictures. Phillipson developed three series of stimuli: (1) those in which light achromatic shading provides the least information, (2) those in which harsher black and white shading is used and forms are more defined, and (3) cards utilizing color. These three styles are used in three pictures each of one person, two persons, three persons, and groups; there are 12 picture cards and 1 blank card in Phillipson's set.

Phillipson (1955) chose the one, two, and three body pictures in order to elicit preoedipal material as well as oedipal material, and designed the test specifically to study object relations. He did not develop a standardized scoring system, but he and other researchers (Boreham, 1975; Nasielski, 1974; Elkan, 1975) have provided examples of rich case material which has been used in content analyses to make treatment decisions, to facilitate therapy, and to understand patients in the same manner that the "life-statements" of early memories allow.

The ORT was chosen as an additional source of projective material because of the richness of examples in the literature and because it was designed to elicit human images from ambiguous stimuli. Unlike dreams and early memories, ORT data had not been scored previously by the technique chosen to measure and define the nature of internal object representations, developed by Krohn and Mayman (1974). It was hoped that the ORT could add to the usefulness of Krohn's scale, but this did not prove to be the case.

Scoring Methods in Measuring Object Relations

Later researchers have designed new methods of scoring already existing projective tests. The theory is that, when presented with ambiguous stimuli, the subject's ways of interpreting and giving meaning to perceptions reveal a great deal about the nature of the internal representations of the self and others, in addition to the traditional inferences as to organization, cognitive processes, personality and defensive style, and impulse control. Images of humans are of special interest in this endeavor.

Blatt, Brenneis, Schimek, and Glick (1976) studied object concepts presented on the Rorschach in both a developmental study (37 normals, ages 11-30) and a study of 48 adolescent and young adult inpatients. They scored human, quasi-human, and human-like animal percept responses for structural qualities: the degree of differentiation, articulation, integration, and accurate considerations of form. Scoring was based on a specified "microscopic" point system. Blatt et al. found that as normal subjects get older, their Rorschach productions contain more full human responses (in contrast to animals, monsters, quasi-human percepts). The human percepts are described more completely with both perceptual and functional detail, and they are more frequently engaged in positive and meaningful actions. For example, an adult might see "two men in coat-tails sitting down at a table to eat," a response in which fully human percepts are described with some detail in a purposeful action.

In the inpatient sample there were more inaccurate perceptions (poor form responses), and the more disturbed of the patient sample tended to elaborate these poor percepts, portray them in unmotivated, nonspecific activities, and characterize the interactions as more malevolent or benevolent. In contrast with normals of approximately the same age, patients gave more human responses at low developmental levels (that is, quasi-human, distorted, unmotivated, incongruent, nonspecific, malevolent, and passive) in their accurately perceived percepts and more developmentally advanced responses on the inaccurately perceived responses. The hypothesis that the development level of internal object portrayal on Rorschach responses should indicate the degree of psychopathology proved to be too simplistic. Blatt et al. discussed their findings as follows:

Thus our data suggest that there are at least two dimensions in the psychotic experience. First, when contact with conventional reality is maintained, the psychotic individual functions at a developmentally lower level and perceives and experiences the world as distorted, malevolent, and destructive. The second dimension indicates that psychotic patients have a greater proclivity for experiencing the world unrealistically but that within these unrealistic experiences they are able to function at developmentally higher levels and experience the world as kind and benevolent. For psychotic patients, adequate interpretations of reality seem to be painful and disruptive experience, and the patients retreat and withdraw to find comfort and peace . . . It is only in the most seriously disturbed patients, those with severe boundary disturbances, that both accurately and inaccurately perceived responses seem to be at lower development levels. (Blatt et al., 1976, pp. 371-372)

Blatt's conclusions suggest that a developmental view of object relations may be oversimplified in its application to adult psychopathology. The psychotic person's "advanced" elaborations of inaccurately perceived forms suggest that there may be several dimensions

involved in the object representations of disturbed individuals. This may offer an explanation for the tolerance of aloneness in schizophrenic withdrawal.

Mayman and his colleagues took a different approach to the task and have obtained results consistent with a straight-forward developmental theory. Mayman focused primarily on content rather than on structure in analyzing projective materials. He commented, ". . . the distrust of manifest content is appropriate only in the context of id-psychology" (Mayman, 1968, p. 303). Rather than studying only the repressed, he saw the opportunity to glean information about the ego, its ways of maintaining repression, and patterns of object relations from the manifest content of Rorschach productions, early memories, and dreams. He came to rely on the judgments of trained clinicians in developing a scoring system, rather than assigning point values to specific attributes. Rather than attempt to break down and score all the microscopic "bits" of information present as did Blatt et al., Mayman and his colleagues used the often intuitive, difficult to analyze global judgements of clinicians, as they considered this a more useful and revealing approach.

In 1967 Mayman reported that clinicians' judgments of human Rorschach responses excerpted from protocols correlated significantly with the therapist's health-sickness ratings in several areas: severity of symptoms, ego strength, quality of interpersonal relations, anxiety tolerance, level of psychosexual development, patterning of defenses, and motivation for change. He also noted that the seven

best psychiatric residents at the Menninger Foundation could be distinguished from the seven worst residents on the basis of human Rorschach responses alone.

Later Urist (1977) asked trained clinicians to rate human Rorschach responses on a "mutuality of autonomy" scale. Clinical judgment is clearly required to transform the human percepts into the seven point scale which ranges from figures portrayed in a manner showing "reciprocal acknowledgement of their perspective individuality" to relationships characterized by an "overpowering, enveloping force" which devours or overwhelms helpless figures (pp. 4-5). Urist's average "mutuality of autonomy" Rorschach scores correlated positively with the same scoring method applied to an autobiographical statement and, more significantly, with a scoring of interpersonal relationships observed by ward staff (who did not have access to test protocols). Urist reported that the staff ratings provided the most optimistic view of the patients' internal objects, particularly when compared to the Rorschach.

Urist's conception of mutuality of autonomy was later elaborated by Krohn, who developed an object representation scale for dreams. The scale measures the level of object representation, a concept Krohn reported was distilled from the works of Klein (1948), Fairbairn (1952), Guntrip (1971), Winnicott (1957), Kohut (1971), and especially Kernberg (1966). The scale includes the following elements in its scoring system: degree of differentiation of self and other (a concept incorporated in Urist's mutuality of autonomy), the degree of

modulation and specification of affect, and the degree of richness of the percepts while simultaneously maintaining an image consistent with reality. Krohn modeled his scale particularly on Kernberg's theoretical work. Kernberg (1966) wrote that the internalizations which compose personality structure are "metabolized" at varying developmental levels. The most primitive internalizations are likely to be marked by undifferentiated, overwhelming affect. Primitive object representations will not be reliably differentiated from one another, leading to a lack of a sense of self as separate in addition to a lack of meaning and purpose to human action. In contrast, Kernberg describes a mature form of internalization as the formation of "ego identity," in which earlier identifications are consolidated and unified. As Krohn and Mayman explained, "Object and self-images become richer, more varied, more consistent, and more congruent with what objects are really like (Krohn & Mayman, 1974, p. 448).

Krohn's scoring manual (used by Krohn & Mayman in 1974) presents an eight point scale of global descriptions of object relationships. The scale ranges from an object world portrayed as lifeless or alien to dream characters who are more or less interchangeable stereotypes, to representations of fully human beings with motives, feelings, and conflicts on which the subject comments and seems to understand at a level beyond the character's gratifications of the subject's needs. Thus, the scale runs from the primitive undifferentiated to the differentiated, from the split object to the whole object, and from the object portrayed only as she/he relates to the subject's needs to an object

portrayed realistically with differentiated motivations and feelings. (See Appendix A for the scale.)

Krohn and Mayman (1974) used this manual to score dreams, early memories, and human Rorschach responses. This means of measuring the nature of object representations could be used reliably by different judges. The ratings of dreams were shown to correlation significantly (.001) with a therapist and supervisor's assessment of a patient's internal object relationships, a judgment made after working with a patient extensively. To a lesser degree of significance, Rorschach object representation scores also correlated with the therapist's judgment (.05), as did early memory scores (.01). Interestingly, dream and early memory scores did not correlate with the therapist's health-sickness ratings of the patients. The authors suggested that health-sickness may be a variable which is distinguishable from the level of object representations. An interaction effect indicates that early memory test scores taken in combination with modal dream scores were a more powerful predictor of a therapist/supervisor's object representation rating than either score alone. The same was true of a combination of Rorschach ratings and dream ratings. A combination of modal dream scores and early memory ratings was the most powerful combination, nearly as effective in predicting therapist ratings as the three projective ratings together.

For this study, then, a series of dreams and early memories were rated by trained clinicians using Krohn's Object Representation Scale for Dreams.

Measuring the Capacity to Tolerate Physical Isolation

The intention in designing a measurement of the capacity to be alone was to determine the degree to which an individual feels comfortable with physical aloneness. A measure of a person's preference for solitude versus socialization was not desired, simply a measure of the ability to tolerate aloneness without anxiety, restlessness, or panic. A relatively straightforward approach was taken in which the subject was asked directly about his or her experiences of aloneness. A structured interview was used to gain phenomenological data about the experience of aloneness, as well as asking questions designed to confirm or refute comfort in aloneness. A minimum of demographic information was asked (age, sex, number of children, and whether or not employed). In assessing the subject's attitude towards aloneness, he or she was asked how they used the term "alone" in conversation, how many hours were typically spent alone per week, the types of activities engaged in when alone, the frequency and nature of feelings of discomfort when alone (barring situations of real physical danger), behavioral reactions to these uncomfortable experiences, the lengths to which the subject might go to avoid aloneness, and the effect of aloneness on the subject's mood (refer to Appendix B).

CHAPTER 7

METHODOLOGY

Subjects

Subjects for the research were solicited from patients of two University of Tennessee outpatient treatment agencies: the University of Tennessee Psychological Clinic and the University of Tennessee Student Counseling Services Center. First, therapists and supervisors were informed of the study and the need for subjects 18 years or older, capable of recalling dreams. Then, secretaries of the two agencies were instructed to hand out notices (see Appendix C) informing clients of the nature of the study. An honorarium of \$1.50 was offered as an enticement for participation in the interview on aloneness, which lasted approximately an hour; a \$6.00 honorarium was offered to those subjects selected for participation in the second phase of the study. The small monetary incentive was offered to lessen the impact of self-selective factors, that is, to lessen the probability that volunteers would have special interests or conflicts about aloneness.

Thirty-three of the subjects were therapy patients from the Psychological Clinic; 25 subjects were from the Student Counseling Center. Fifty-eight subjects were interviewed; 2 of these subjects were not included because they appeared to be actively psychotic, clearly distorting and contradicting themselves in important ways in their self-reports. Of the 56 subjects, the average age was 27 years (with a range of 18 years to 54 years); 36 of the subjects were

students at the University of Tennessee, Knoxville (21 undergraduates, 15 graduate students). There were more female volunteers (37) than male volunteers (19). Thirty-six of the subjects were single, 8 were married; 12 were divorced. A minority of the subjects (9) had children. Seventeen of the subjects worked full-time; an additional 18 subjects worked part-time to full-time while attending school; 3 subjects were unemployed. Only 23% (13 subjects) lived alone; the rest of the subjects lived with a roommate (18 subjects), with a girlfriend, boyfriend, or spouse (15 subjects), with their family of origin (7 subjects), with a child (1 subject), or in a combination of arrangements (2 subjects).

Phase I--Interviews

Phase I consisted of interviewing the volunteers about their experiences of aloneness. The interview was structured, designed to gather information about the subjects' experiences of aloneness: their definitions of aloneness, the amount of time spent in physical isolation per week, experiences of discomfort caused by aloneness, what the subjects did when they became uncomfortable with aloneness, the relation of the subject's mood to his or her experience of aloneness. The interview questions (not necessarily presented in the order given) are attached in Appendix B. The interview was designed not only to provide phenomenological data, but also to provide a basis for rating the subjects' tolerance for aloneness and thus screening for two groups of subjects needed to participate in Phase II.

Subjects indicated interest by returning the notice with their name and telephone number; the experimenter contacted each volunteer by telephone to schedule the interview. Before beginning the interview, each subject read and signed a statement of informed consent. This statement (Appendix D) described the research project as "designed to test some theoretical views on people's experiences of aloneness," outlined the nature of the participation, the time demands, and payments that could be expected, and specified the subject's right to withdraw consent or cease participation at any time. The measures to ensure confidentiality were enumerated: labelling subjects' tapes and statements with a code number rather than a name, deleting or altering identifying information prior to publication. Included in the form was a special release of information authorizing the subject's therapist to rate the subject's tolerance of aloneness and release this information to the experimenter. The researcher stated clearly that no other discussion would occur with the therapist.

Rating Tolerance of Aloneness

The first 36 interviews were typed and labelled with a coded number. The researcher and a rater (an experienced clinical social worker) discussed the rating scale (Appendix E) and their ratings of 6 sample interviews. They then independently categorized each subject as having high tolerance of aloneness, average tolerance of aloneness, or low tolerance of aloneness. One-third of the subjects were rated and disagreements were discussed before the remaining two-thirds of

the subjects were rated. Due to the unexpectedly high interrater agreement (89% agreement) on the first 36 interviews, the experimenter rated the remaining 20 interviews without additional validation.

The assumption behind the development of a tolerance of aloneness rating scale was that some individuals consistently have more difficulty than others in tolerating physical aloneness. The purpose of the scale was not to measure preference for aloneness versus the presence of others' company, but to measure the subject's tolerance for alone times. An interview was rated with special attention to the nature and frequency of the uncomfortable feelings described in aloneness (especially the degree of urgency, panic, or desperation) as well as to the subject's reported behavioral responses to the discomfort. More selective, direct, and productive coping styles would indicate high tolerance; unselective, indirect, and especially self-destructive coping styles would be consistent with a low tolerance rating.

The subjects' therapists were asked to rate their client's tolerance of aloneness using the same scale. They were instructed to make a rating based on their knowledge of the subject through therapy contacts or to indicate that they had insufficient information. In other words, therapists were not asked to further question their clients about possible discomfort in aloneness, but to use information already available to them. Thus, therapists and raters used different "data bases" upon which to rate the subjects' tolerance of aloneness. Raters looked at transcripts of interviews (of about an hour's duration), which were designed specifically to clarify the subject's degree of

comfort or discomfort in physical aloneness. As expected, agreement between therapists and raters was not nearly so high as the 89% figure between the two raters. One can speculate that therapists had a great deal more information on which to base a rating in some cases and probably a great deal less in others, depending on the topics discussed in therapy and the length of treatment. Therapists were given no training or practice ratings; they were simply asked to read the scale before making ratings.

The purpose of the screening interview and rating method was to obtain two groups of subjects: a group highly tolerant of aloneness and a group with relative intolerance of aloneness. Subjects were selected for these two groups only when all the ratings agreed. Thus if both raters (for the first 36 subjects) agreed, and the therapist also agreed with the raters (if a rating was made by the therapist) that a subject had either high tolerance of aloneness or low tolerance of aloneness, only then was a subject selected for Phase II. Cases in which therapists declined to rate subjects due to insufficient information were included if both raters agreed on a high tolerance or low tolerance rating.

Subjects chosen by this process were then notified by phone and were scheduled for the testing session, which involved collection of early memories, administration of the Object Relations Technique, and instruction for collection of the subject's next five dreams. Nineteen low tolerance subjects and 8 high tolerance subjects fit the criteria. Unfortunately, between the time of the interview and the time of

notification, seven of the selected subjects had moved and one had become so busy in his seasonal business that, after three failures to attend appointments, he dropped out of the experiment. Efforts made to locate subjects who moved (without betraying confidentiality) were successful in two cases. Telephone interviews were arranged for these two subjects who had moved out of state; Object Relations Technique picture cards were mailed to the subjects with instructions to wait until the time of the telephone interview before looking at them. In the end, 14 of the 19 selected subjects participated in the low tolerance group; 7 of the 8 selected subjects in the high tolerance group.

Phase II: Testing of High and Low Tolerance Subjects

Phase II, the collection of projective data on the selected subjects, began with the Early Memories Test. The following instructions, developed by Eva Ferguson (1964), were used:

I want you to tell me some incidents you can remember from your early childhood. Start by telling me the earliest incident you can remember. What I have in mind is a scene or event that you can actually remember and not just an event you were told about. I want you to tell me everything that happened in this incident, including how you felt at the time. I will write down what you tell me so please go slowly enough for me to get everything down. Tell me for each event about how old you were at the time the incident took place. (Ferguson, 1964, p. 405)

In addition to the earliest incident, the subject was asked for the earliest memory of the mother and the earliest memory of the father. Additional memories spontaneously offered by subjects were also recorded (written down verbatim).

Next, the experimenter administered the Object Relations Technique. Ten of the Object Relations Technique cards were given in the order specified by Phillipson (1955). The nine cards picturing one person, dyads, and triads were chosen, as well as one group picture which Phillipson (1955) described as eliciting loneliness themes. The following instructions were given:

I am going to show you some pictures. Will you look at each one as I give it and try to imagine what it could be. As you bring it to life in your imagination, make up a brief story about it. First of all you should say how you imagine this situation came about--this you can do in one or two sentences.

Then you can imagine what is going on in the situation and tell me about it more fully.

Finally, imagine how it turns out, or what happens in the end--this final part you can do again in just a sentence or so.

The story is to be done in three parts; the beginning, the middle bit which you do more fully, and the ending. I suggest we do the first one as a sample, then you ask me about it afterward, and I will tell you whether it is all right. (Phillipson, 1955)

On the first card, follow-up inquiries were made by the examiner. Stories were written down verbatim by the experimenter, and later typed and labelled with a code number.

At the end of the session, the subject was told that a series of his or her next five dreams were needed. Specifically, the experimenter asked each subject to write down his or her next five dreams or dream fragments upon awakening in the morning. It was suggested that the subjects keep paper and pencil at their bedsides to facilitate the dream collection. Subjects were given stamped, coded envelopes addressed to the researcher, in which to send dream reports. The experimenter asked if the subject could recall a very recent dream at

the time of the testing session; if the subject recalled a dream which occurred within the week, it was recorded. A minimum of three dreams was collected for each subject.

On the statement of informed consent, subjects had given the researcher permission to contact them by telephone to check on progress towards completion of dream reports. Some subjects were contacted two to three times to check on their progress, and to remind them to send in reports.

Development of the Scoring Technique

The experimenter's original plan had been to have two trained judges score each memory, story, and dream by using the Krohn Object Representation Scale for Dreams (Appendix A). However, the experimenter's attempts to use Krohn's scale on the Object Relations Technique stories were not successful. Many of the minimal stories did not seem to involve enough projection to be scorable by the method; it was very difficult to decide between rating such stories a "5" on the scale, for their shadowy, interchangeable figures or to consider them unscorable. In a personal communication with the experimenter (April 20, 1985), Dr. Krohn expressed his feeling that the Object Relations Technique data were not ideal for use with the scale for the same reason that TAT stories had not been effective: in his dissertation research, Krohn (1972) found that there were too many external stimuli in the pictures to allow adequate projection to occur for many subjects. Thus, the stories were more like reactions

to stimuli than projective expressions which could be used to measure object representation development. Blatt et al. (1976) had also found TAT stories to be least useful of the projective measures used with the Blatt scale of object relations development.

In addition, the stories seemed more affected than the dreams and early memories by the subject's knowledge that the study concerned tolerance of aloneness. Many stories seemed to focus on reasons for a character's comfort or discomfort in aloneness. One subject articulated his experience of experimenter demand: "You know I look at all these pictures when one person is apart, like I'm having a hard time not reading into the purpose of the test and going for that." He said later, "My mental set is to say something about aloneness, then I resist my initial set."

Because of the scoring difficulties using Krohn's scale, a different means of scoring the ORT stories was needed. Six scales were developed by the experimenter to examine in a rather concrete fashion some dimensions of the stories believed to bear on object relations development. They are presented in Appendix E. The scales were: (1) degree of projection or enlivenment (a 4-point scale), (2) degree of character description (a 4-point scale), (3) degree of description of physical setting (a 3-point scale), (4) degree and complexity of interaction (a 4-point scale), (5) valence of interaction (a 5-point scale), and (6) valence of physical setting (a 5-point scale). In addition, a count was taken of the number of words per story.

Two judges trained in the scoring method independently rated the experimental subjects' stories on the six scales. Stories had been typed and labelled with code numbers.

An additional two judges were chosen to use Krohn's scale on the dreams and memories. These were advanced graduate students in clinical psychology with training in object relations theory. After practicing on hundreds of sample dreams and memories, the judges were given packets composed of the typed dreams and memories, presented in a random order. (At times when a subject made a comment which seemed to apply to a series of dreams, the series was presented in its original order.) Judges rated these productions independently, but met six times to discuss disagreements after having scored a portion of the productions.

CHAPTER 8

RESULTS

Analysis of Interviews on Aloneness

Definitions of Aloneness

As became increasingly clear during the research, aloneness is a relative and quite complex concept. Nevertheless, it is a term that most subjects used freely and defined without hesitation. When subjects were asked how they used the word "alone," 77% of the 56 subjects interviewed responded initially by describing physical isolation in simple terms ("by myself," "no one around"). This description referred to a fairly consistent degree of physical isolation: alone in a living space (dorm room, apartment, or house), usually with access to a telephone, as well as representations of others (television, radio, records, books, photographs, letters). A small minority of this group described a greater degree of isolation ("really alone") as being alone in a setting miles from the nearest neighbor, as unplugging the phone, or as being alone in the mountains without a radio. For many, the experience of physical isolation might occur within shouting distance of another person, however.

In the course of discussion, many subjects altered or added to their initial definition of "aloneness." For example, eight subjects altered their initial definition "no one around" to mean no interactions or verbal communication. Thus, these subjects used the term alone to

describe studying in a carrel in a crowded library, being at home with a spouse asleep, riding a bus unaccompanied, etc. Several subjects mentioned that communication with pets, through musical recordings, and through books made them feel "not really alone."

A second enlargement of the concept involved mental or emotional isolation, as opposed to physical isolation. Here, subjects spoke of a lack of meaningful emotional contact or "relationship deficit." Eighteen percent of the subjects (10 subjects) clearly distinguished feeling alone (emotional aloneness, loneliness) from being alone. Feeling alone might or might not occur with physical isolation. For some subjects emotional isolation and loneliness were more likely to occur with others. An additional 22 subjects (39%) mentioned the notion of this "mental aloneness" when with other people, in addition to physical isolation, thus implying a distinction. For example, when asked what she meant by alone, one subject stated:

Well, it's a two fold answer. Alone, meaning single, no other personal contact, as say the dictionary may describe it, and alone in the sense of "I'm feeling alone." I mean I have had that feeling where I could be in a group of people, at a party or something, and feeling very alone. Even though you're surrounded by other individuals, either you don't know those people or you're not in a social mood, or for some reason you're not making contact with anyone and things go whizzing by you. And then alone in my relationship where my husband is there but I'm just thinking to myself, "We are not making contact here." I feel very lonely, alonely.

Several subjects described the phenomenon of feeling "alone in a crowd," and noted that the feeling of distance or lack of contact could occur when engaged in a conversation. One woman stated that a time

when she regularly experienced a feeling of aloneness was during sexual intercourse, because "you are not sharing what is happening and you are not sharing emotions and you are not sharing common feelings or common goals."

Many respondents articulated that the longing for contact occurs in the context of a sense of alienation. The feelings of being different: "not belonging"; "not fitting in"; unable to trust or talk to others; and not being understood or having someone to care about personal feelings comprised this sense of distance. For these respondents, the problem seemed to lie "out there," in the absence of understanding and caring others. For nine subjects, the source of the alone experience was internal. One woman defined aloneness as "not feeling the ability to communicate my needs and feeling a bit helpless in that inability."

A man articulated this concept of aloneness with the following statement, ". . . inside my own mind when I think about being alone, it doesn't have too much to do with who is in the room or not in the room, or whether I know them. It is a state of mind I can enter . . . regardless of the crowd [or person] I was with. . . ." For this man, aloneness was a problematic emotional distance which he created by erecting an "invisible barrier" between himself and others. Nine subjects (16%) described aloneness in terms suggesting their own responsibility for closing themselves off, withdrawing, or an "emotional removal of myself."

Connotations of Aloneness

For 11% of the subjects interviewed, aloneness was equated with loneliness, in contrast to those subjects who clearly distinguished the two, and those who used "alone" to mean both physical isolation and mental isolation. These subjects seemed to be suffering stresses (break-up of a relationship, move, etc.) which made them view alone time as negative. For each and every subject, aloneness had powerful affective connotations, frequently both positive and negative. Before analyzing types and sources of the negative connotations, it is important to understand the positive connotations of aloneness for the subjects.

Every subject, even subjects who described intense suffering in aloneness, mentioned certain circumstances and/or activities which led the subject to prefer and seek physical aloneness. Even the subject who stated "I hate to be alone . . . I don't think I'm able to be alone . . . it just turns out I am" admitted that he preferred to be alone to concentrate on school materials he had trouble understanding. One positive connotation articulated by 80% of the subjects was "productive time," or "absence of distraction." One woman stated, "There are some things I can only do alone--write poetry or paint, for example." Four subjects who were writers, and five subjects who painted and sketched noted that solitude was essential in the creative process. ("It irradiated the possibility of outside influences"; "I don't like my concentration to be broken"; "There's hell to pay if I'm interrupted"; "It is an inherent part of what I like to do that I must be alone to do

it, in that nobody can sit there and hold the pen with me, or type the keys with me. And I can't talk at the same time that I write.") The connotation of heightened concentration and "getting things done" applied not only to creative acts, but to housework, hobbies such as dog-training, studying, business decisions, reading, and practicing music, to name a few.

Another positive connotation, especially true for subjects with several roommates, was "privacy" and "quietness." Thirty-two percent of the subjects mentioned these concepts. One subject stated of her "treasured times" in the early mornings, "I just get this feeling of satisfaction in the quietness. I can hear the quietness and I really become resentful if that's disturbed."

Closely associated was the quality of freedom. Forty-eight percent of the subjects referred to alone time as personal time, "my time," characterized by freedom from demands and responsibilities to others. A mother of a young child, who was a full-time graduate student, defined aloneness as time when "my schedule is responsible to me and what I have to do, and I can pick and choose the activities, set my own priorities, and see accomplished what I need to see accomplished in a given period of time." A young woman who lived with her family stated:

Being alone to me is being free to think what I want to think, to feel the way I want to feel, to do what I want to do if the mood so pleases me--to satisfy me and make me happy, not worry about anyone else or taking care of anyone else or watching out for anyone else.

For her alone time "is necessary for physical and mental survival." Two other subjects specified alone time as "essential," also.

For over half of the subjects interviewed (55%), aloneness connoted the opportunity for a special kind of thinking or self-assessment. As one subject put it, "I think and feel by myself in a way that I don't with others," and another, "I think best when I'm alone." Five subjects mentioned specifically the opportunity to identify their own thoughts or feelings: "It's an assessment tool--to talk things over with yourself, just kind of find out how you're feeling and what you're wanting." This was important for one subject in the following context:

Sometime, you know, a relationship can be very stressful, you know, and you kind of don't know any more what you feel about those things because you react so much . . . then it's time to kind of go away and see what your feelings are, concentrate on yourself a little bit more, decide things.

It is the time for "being honest with yourself," "accepting myself," "getting my life together," "for reflection," "for really contemplating myself and my relationship with God." One subject articulated its organizing function implied in "getting my head together": "When everything is so hectic . . . it is just busy, busy, busy and I lose perspective of . . . the organization of my life and I tend to use my alone time to organize what is going on." It is for many (23% of the subjects) a chance to "work through" or "sort out" an emotional reaction.

Four subjects mentioned a "philosophical aloneness." One defined it as:

. . . the basic realization that when it gets down to it, you are just basically alone "(?)" In terms of depending on other people for different things, not just physical support,

but, say, emotional support. And I think there have been times when I felt like I had sort of reached the end of that rope and that basically there was nothing left but myself. And I sort of had come to terms with that on occasion.

In the same vein, a man versed in existential writings said, "Part of the human experience is to be isolated. There is comfort in communication, but we're fooling ourselves to think we're not alone when with people." A woman noted that "When I was married I was an extension of someone, of a relationship. Now it's more like I know that I am more or less by myself."

Another subject had an opposite view of aloneness. Rather than the philosophical notion that we are all "basically alone," he made the case that "nobody is really alone." For him, "alone time is a treasure because we paradoxically realize we are not really alone. Aloneness is a terribly important opportunity." He noted that meditation brings about a sense of "harmony and contact."

One positive connotation of aloneness had to do with independence. Eighteen percent of the subjects commented on the notion that aloneness "teaches you to depend on yourself." A young woman, who described her efforts to break off a dependent, abusive relationship, described aloneness as "an eye opener":

I couldn't leave him . . . until I was out on my own for a little while and saw that I could do it and that I am ok, and I don't need that reinforcement from him constantly. . . . When I am alone, I am autonomous. I feel much better about myself now and I think aloneness has really been a positive thing, although during periods it has been pretty bad.

A negative aspect of independence espoused by two subjects was "having to do everything myself."

Another positive association to aloneness articulated by 25% of the subjects is a lack of inhibition or "social front," which is sometimes viewed as valuable to allow ventilation. One woman said that when alone and depressed she would "feel more free to cry, to get some of my feelings out." Another stated: "I feel relieved not to have to deal with anyone or put up a false front," similarly, "I wouldn't have to suppress anger to be socially acceptable."

Further positive connotations include feeling "more relaxed" (14%), feeling "in control" (9%), self-protection from potential hurt (9%), peace (4%), and "essential" (5%).

The most common negative connotation of aloneness was loneliness, although this was equated with aloneness by only 11%. Nevertheless, loneliness or a longing for contact was a form of discomfort mentioned as being sparked by physical aloneness by over 75% of the subjects. Other negative connotations (such as alienation and differentness, boredom, restlessness, self-pity, emptiness, anxiety, magnification of emotions and moods, and vulnerability to attack) will be discussed more fully in the section focusing on the nature of discomfort experienced in aloneness.

Time Spent in Physical Isolation

The number of hours spent alone in an average week was estimated by asking each subject for their weekly routines and counting the hours spent isolated in a living space such as dorm room, apartment, or house or in a large office or laboratory space, not

including time on the telephone. The range was from 4.5 hours/week to 108 hours/week, with the mean number of hours being 34.5 and the median number of hours being 27.5. This report included waking hours only. If one assumes that a person sleeps an average of 8 hours per night, the range represents 4% to 96% of a subject's waking hours, with a mean percentage of 30%. One reason accounting for this wide variation was living arrangements; subjects living with roommates and families usually spent less time alone than those who lived in their own apartments.

Figure 1 shows the breakdown of time spent in isolation, and indicates those subjects satisfied with the amount of time spent alone. Figure 2 illustrates how this estimate compared to the amount of time subjects would prefer to spend alone. The illustrations show that some of the subjects who spend a relatively small percentage of time alone would prefer less alone time. As will be discussed later, the amount of time a person spent alone did not preclude very painful experiences of discomfort in aloneness. It appeared to be a function of living arrangements, of schedules, and of fear of discomfort in being with people; persons who spent greater number of hours alone were not necessarily viewed as more tolerant of aloneness.

Nature of Discomfort in Aloneness

Although 18% of subjects clearly distinguished between "feeling alone" and "being alone," and an additional 39% implied a distinction, almost all subjects could describe discomfort they had experienced at

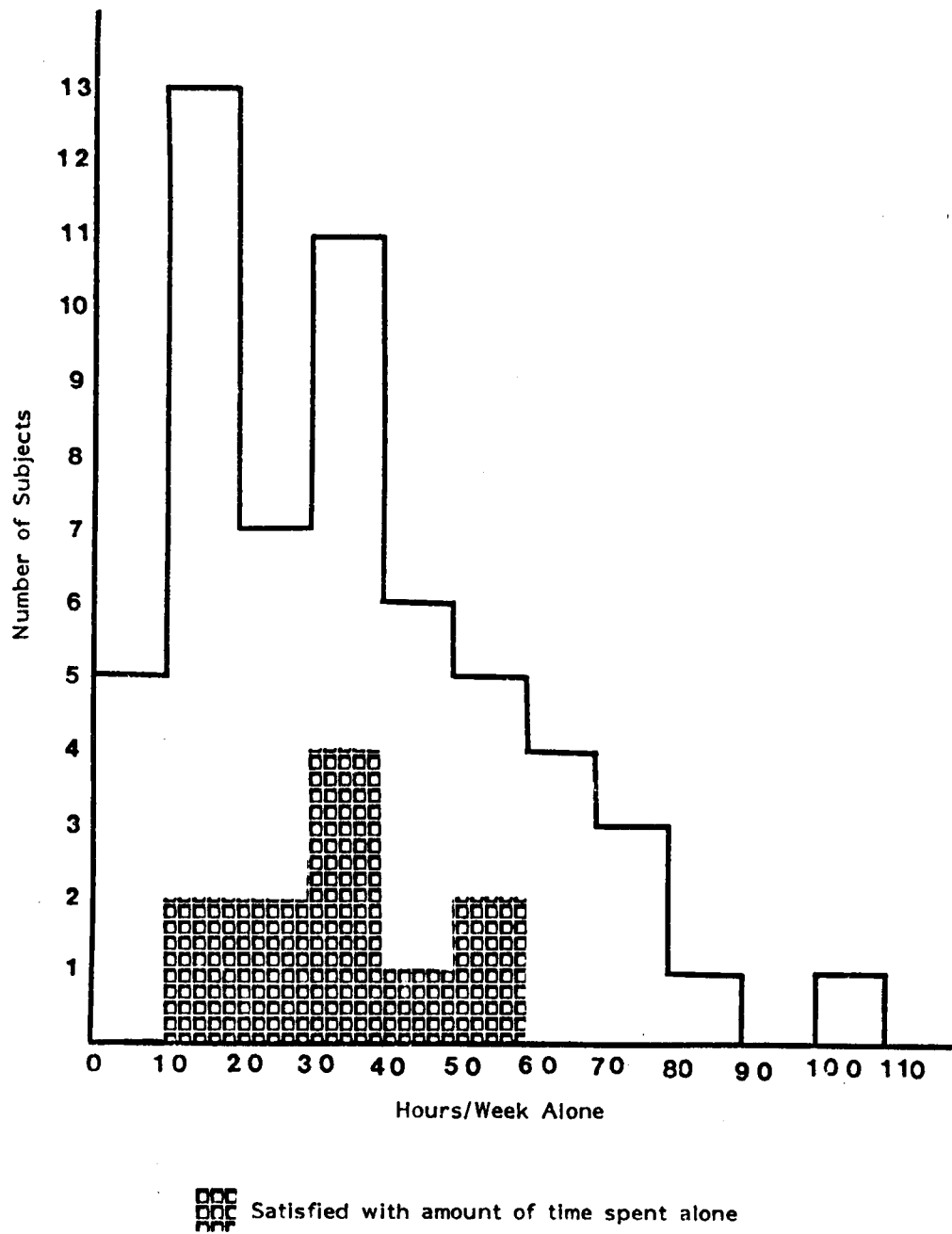


Figure 1. Number of hours/week spent alone by subjects; number of subjects satisfied with number of hours.

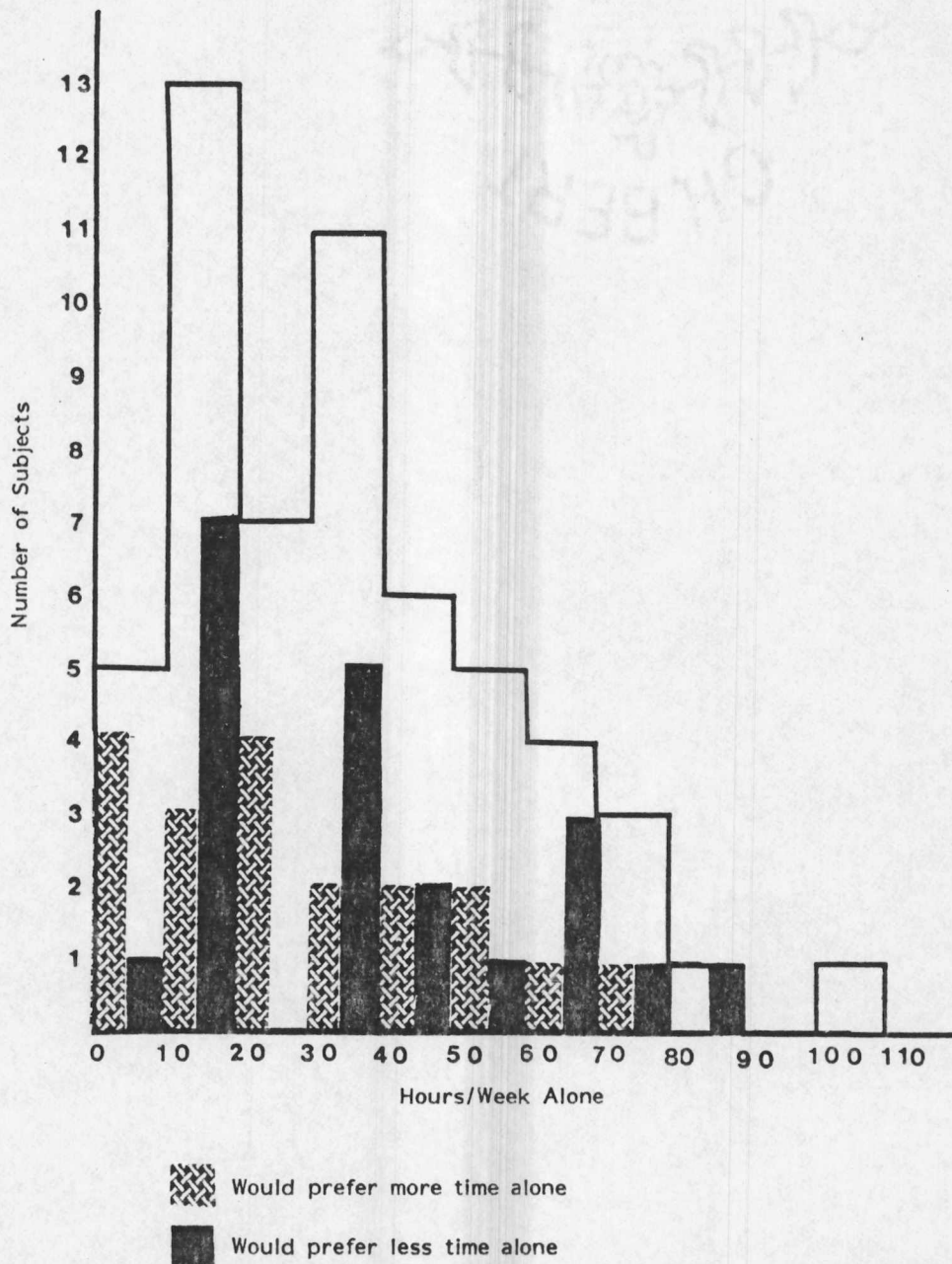


Figure 2. Number of hours/week spent alone by subjects; number of subjects preferring less and more hours alone.

one time or another due to physical isolation. For some subjects, this discomfort was rare and mild, perhaps described as an occasional "wistfulness" or desire to share ideas with someone. For others, it could be a frightening, disorienting experience accompanied by extreme emotional states and fears of suicide or "going crazy." Interestingly, some of the subjects who described very painful experiences of aloneness seemed, for the most part, quite comfortable being alone, spending more than the mean number of hours/week alone, and taking pride in self-sufficiency. No subjects described discomfort occurring with every aloneness experience. For some subjects, loneliness sometimes occurred when physically isolated, but might be more likely to occur in a crowd. Most subjects described more than one type of uncomfortable experience. In summarizing these results, themes were grouped into the following categories: loneliness, anxiety, vulnerability to physical threat or intrusion, fear of going crazy, identity disturbance, and intensification of existing moods. Table 4 presents a summary of numbers of subjects found in each group. (Clearly, there is overlap in these groupings.)

Loneliness

A common type of discomfort reported was loneliness. While the relationship between physical aloneness and loneliness was not usually presented as an equation, the two experiences are "relevant to one another," as one subject put it. Twenty-four subjects used the terms "lonely" or "loneliness," in responding to the question "What types of

Table 4

Types of Discomfort Reported in Aloneness

	Number of subjects (N = 56)	Number of low tolerance subjects (n = 14)	Number of high tolerance subjects (n = 7)
Loneliness			
"Lonely"	24	6	3
Yearning for emotional contact	13	2	2
"I want somebody to talk to"	12	3	1
"There is no one to talk to; no one understands"	13	4	3
Differentness, not belonging	12	4	0
Desire to share or communicate	11	0	3
Desire for physical contact	4	0	0
Self-pity	10	3	1
Emptiness	5	1	0
Anxiety			
Restlessness	11	5	3
"Anxiety"	21	5	0
"Panicky"	8	2	0
"Hours to fill up"	4	r	0
Magnification of existing anxiety	20*	8*	2
Boredom	15	5	2
Vulnerability to physical threat	9	4	1
Fears of going crazy	8	2	0
Identity disturbances	4	0	0
Depression or magnification of existing depression	43	11	6

*4 implied.

discomfort have you experienced due to being physically alone?" However, as noted, some clearly stated that the loneliness was not so much a response to physical aloneness as mental aloneness. Thirteen subjects described a yearning for contact (often intimate communication) as sometimes occurring in physical isolation. One subject articulated this discomfort as a need for:

. . . a person that was close, not just any people, but someone that was an intimate relation--whether it was a sexual relationship or not, but that lack of intimacy to me is what triggered a lot of depression. And it's very different from being with people: you can be with a group of people and yet not be with intimate friends and it may serve some functions but it won't serve, for me, some of the deeper needs.

Thirteen subjects described wanting someone to talk to. Eleven subjects described a desire to share an experience or communicate an idea, an experience which seemed more like a passing frustration than a painful sense of loneliness. Four subjects mentioned the desire for physical closeness in the context of loneliness. Seven subjects noted the feeling of having "no one to talk to," and seven reported feeling "no one understands." The nature of these feelings varied from a passing idea: "Gosh, I ought to call so-and-so," to a sense of complete isolation, often accompanied by a desperate or helpless feeling: "lonely as if I'm the only person in the world." These groupings, incidentally, are not mutually exclusive. To explain, the total number of subjects describing the sensations of loneliness, yearning for contact, wanting someone to talk to or feeling that there is no one to talk to or who understands was 44 subjects (79% of

subjects), of whom 28 were female. Male to female ratio approximated that of the overall study.

It is evident that many subjects focused on a lack of meaningful communication or support with an understanding person. Some words used to further characterize this uncomfortable experience were: "empty" (5 subjects), "isolated" or "unconnected" (13 subjects), and "left out" (2 subjects). Ten subjects articulated that they sometimes experienced self-pity when physically isolated: "I just start to feel sorry for myself." Twelve subjects (21%) expressed a sense of isolation stemming from being "different" or "outcasts": two subjects because they were gay; one because he was a Catholic from the North living in the Bible Belt; two because they were living in a foreign country and speaking a foreign language; one because he felt more intelligent and articulate than the "rednecks" with whom he worked; one because she felt her divorce made her unlike her friends and coworkers (all of whom had intact families); one because he felt he didn't "belong" to his family; one because she felt different from other church-goers and like she did not belong in her church group; one because he was highly religious at a school in which drinking and drug abuse were the norm; one as a schoolgirl when she changed schools and "didn't fit in"; and one because, as a dormitory counselor, she was placed in the undesirable, "different" position of an authority. Thus, while many subjects in their discussion of loneliness pointed to a lack of or inadequacy of a romantic relationship, a painful sense of

isolation could also result from cultural and other differences from family or peers. Two subjects also noted that a sense of isolation could result from feeling cut off from God. Again, this emotional aloneness was sometimes aroused by physical isolation. A male subject who differentiated loneliness from aloneness described loneliness as "an emotionally destructive force" characterized by "sadness and spiritual depletion," which "sucks me like an outgoing tide. I start to lose faith in sensitivity and good; it's devastating."

Nine subjects expressed a fear of being alone or lonely in the future. For some, there was a sense of the "Now is forever" time sense. One subject described extreme anxiety in the context of a problematic romantic relationship; she said, "I thought I was going to stay alone forever. . . . I was scared that everybody was going to lie to me and I was never going to have anybody again." An 18 year old subject said, "I think of myself as being alone the rest of my life." He clarified, "Having no friends and no mate; it scares me." In less dramatic statements, two subjects noted their discomfort in not knowing when their next social contact might occur; "there's no time limit to your aloneness," one said. Five subjects were worried by their sense that they might be alone, childless, single, or lonely as old people. Four of these five blamed themselves: due to an "inability to talk to people," a failure to form friendships, a "handicap" which prevented having a husband or family, and a tendency to "burn bridges," which made the subject "closer to really being alone."

Anxiety

Restlessness. Aloneness was accompanied by a sense of anxiety for many of the respondents. Eleven subjects (20%) reported feeling "restless," "antsy," "cooped-up," or "hemmed in" at times when alone. This restlessness or "cabin fever" seemed to reflect a mild form of anxious discomfort, and also seemed related to boredom.

Agitation/anxiety/panic. Twenty-one subjects (38%) described various forms of a more agitated or fearful state which included a sense of panic or urgency to be with others; this number included reports of discomfort occurring in the past. Three described a form of anxiety which seemed more a reaction to having no mate or other specific issues; these subjects described no accompanying physical symptoms. Five of the 21 subjects, however, suffered full-scale "anxiety attacks," in which they hyperventilated, experienced "chills and shivers," racing heart, muscle tension, insomnia, and/or nervous stomach. Eight subjects (14%) used the term "panic" or "frenzy" to describe their discomfort in aloneness; and an additional three described this agitation as included pacing and being unable to "sit still" and/or impaired concentration. One women describing this state reported that she drank in order to "stay calm." For these 21 subjects, fears were rather undefined; not included in this group were those subjects with fears of intrusion or physical threat. Rather, there is for these subjects an unexplained fearfulness or helplessness. One subject stated of a period in her life: "In a sickly way, [I] had

to be with people." Another subject put it, "I have to get someone to talk to me or else!" For one woman, the anxiety was expressed as being "full with doubts," "scared and insecure" and was accompanied by a multitude of fears of catastrophe (atomic bombs, being poisoned). Other accounts of this discomfort included phrases such as "afraid," "desperate," "scattered," "not knowing what to do," "helpless," "confusing and hectic." It was 4 of these 21 subjects who, when discomforted by aloneness, saw time as "hours to fill up" or endure "without knowing what to do."

It is important to understand that the panicky feelings described were for many subjects an infrequent occurrence. Subjects had some difficulty estimating the frequency of the anxious episodes, and for some it was connected to a specific life experience such as divorce, a specific relationship, the end of the college quarter, etc. Of the 13 subjects who gave estimates of frequency, 4 subjects had occurrences one or two times a month or less; 2 subjects had occurrences four to eight times a month; 3 subjects had occurrences 8 to 12 times/month; 1 subject described a rather mild anxiety occurring 12 to 16 times/month; 2 subjects described this discomfort as occurring 20 to 30 times/month. The ratio of males to females experiencing this type of discomfort matched the overall ratio of males to females participating in the study.

Intensification of anxious mood. When subjects were asked about the effect of physical aloneness on an anxious or worried mood, 36% reported that the anxiety intensified, and an additional 7% implied this

by reporting that they would seek out others. One subject, recently graduated, said ". . . the anxiety of daily life becomes magnified when I'm alone. I mean, if I'm feeling helpless and overwhelmed, if I'm alone I feel more so." For these 43%, the presence of another seemed to alleviate the anxiety by providing reassurance, something "to keep my mind off of it," and by getting "my logical part going." Sometimes, subjects reported they were able to interrupt the spiraling effect by finding things to do while alone.

Boredom. Fifteen subjects (27%) reported boredom as a type of discomfort. As one subject put it, "no activities fill me after a while. . . . Everything gets boring. I need some stimulation or an exchange of ideas." Other phrases common in this grouping include: "bored," "cut off from activity," "tired of being with myself," "I can't find anything to do." The male to female ratio was the same ratio as male to female participants.

Vulnerability to Physical Threat

Included in this grouping were nine subjects, all females, who complained of discomfort in aloneness related to fear of robbery, rape, or other physical threat. This 16% of the subjects were aware that their fears were for the most part unrealistic. (Not included in this group were subjects who reported fearfulness as a reaction to a realistic source of threat such as a rash of robberies occurring in the dormitory, physical threats from an ex-husband, or aloneness in an unfamiliar and unsafe area of town.) The nine women expressed a

sense of vulnerability which most frequently occurred at night when going to sleep. A woman who occasionally backpacked unaccompanied experienced "creepy, paranoid feelings." She said, "I guess it is the threat of being raped or killed or just scared by somebody that bothers me; it is not being out in the woods." A subject who spent several months house-sitting in a large house in a wealthy neighborhood described her terror as she lay awake listening for strange noises: "I picture an axe murderer," "someone watching." This woman slept uneasily holding her nunchakus (a martial arts weapon) for protection. Another woman who sometimes feared robbery said she visualized scenes from a scary movie. One subject ruefully admitted that she felt "afraid of the dark," especially in large houses some distance from neighbors. For these women, another's company relaxed the fearfulness and dispelled the threatening images.

Fear of Going Crazy

Eight subjects (14%) referred seriously to a fear of "going crazy" which was offered as an occasional reaction to physical isolation. Five out of the 7 subjects were female, a percentage not far from the percentage of females in the overall study. A young student described the feeling as an "out of control, panicky feeling" in which "I wander around and don't do what I have to do." This subject had sometimes wanted to be hospitalized in order to relieve the pressure. For her and for another female subject, depression and self-criticism escalated when physically alone to the point that there was a fear of craziness.

For a male subject, the trigger to fears of loss of control seemed to be awareness of rage. Another woman described the rare fear that she would not be "normal" the next time her friends spoke to her, and felt urgent needs to be with friends who understood her so she could "relax and rest up." A male subject associated fears of losing control to his "dark periods." This subject believed he suffered manic-depressive episodes which might occur several times a year. Although this man was a writer who worked a full-time job comfortably in isolation and appeared to have a normally high tolerance for aloneness, he became extremely uncomfortable with aloneness during the episodes. He experienced "illogical" panic, and said, "I'm like a wounded animal." Except for close friends, he felt compelled to be alone, despite his discomfort, as he could not "face" others. He reported that he feared self-destructive actions during the "dark periods," such as destruction of his property, and that his fears seemed to feed on themselves because he did not understand his emotions. A woman who also described a usual preference for aloneness noted that there were times when she became so "wrapped up in thoughts" that she hallucinated. She found this "an overwhelming emotional state that I am not capable of comfortably dealing with. It gets out of control." During her discomfort of this nature, she felt she "should" seek out others to interrupt her thoughts, but did not always do so. Another subject similarly implied a fear of loss of reality testing in that "I get lost in my fantasies to the point of not wanting to be around people because they can wake you to reality." Another subject felt she would

"go crazy" if alone and not busy, and described getting "so caught up in what I am thinking that I can't go to sleep" during the time right before she goes to sleep when she cannot be stimulated or busy. Especially in the last case, anxiety states overlap with the fears of going crazy. However, these subjects represent a distinct group in their explicit references to fears of losing sanity or control.

Identity Disturbances

A small percentage of the interviewees (7%) clearly articulated uncomfortable identity problems related to aloneness. Two of the four women referred to identity issues occurring within the context of an overly dependent relationship with a man. These two women seemed to feel inadequate ("unattractive," "uninformed," "untuned") when they did not have access to a "stamp of approval over and over and over again" from their partner. Both described a constant "compulsion" to seek this "reinforcement"; one said it was because she was afraid "the relationship was going to fall apart if I wasn't with the person every minute of the day." Each saw herself as attempting to cease reliance on an external source of self-worth.

For the other two women, the identity issues were more pronounced, not just concerning on affective reaction to the self, but concerning the self's very existence. Once or twice a week, one woman felt "a void," which she elaborated as follows:

I start to feel like I'm not there when I'm by myself, like I don't exist unless I'm interacting with someone. . . . The feeling is like I'm gone, like I'm not anybody unless I'm interacting. Like I haven't been there and I've never been there, like there's no "me" at all. Then I need to talk to someone, to start up the system again.

For this woman, physical symptoms of anxiety and a desperate urgency accompanied the identity disturbance. Another woman reported that when she felt alone, "I don't feel like I'm there, like I'm invisible." This experience, however, was really described as a reaction to feeling alone rather than to physical isolation.

Magnification of Emotional Discomfort

In several ways, discomfort in physical aloneness was caused by a magnifying effect on existing emotional discomfort: anxiety, anger, depression, loneliness, identity problems. Frequently magnification of depression seemed linked to experiences of loneliness. A recently divorced man explained that while breaking up rather than aloneness per se was the cause of his depression, he more frequently became depressed when alone because "I think too much about 'Why am I alone?' and dwell on how bad it feels." For him as well as other subjects, physical aloneness prompted awareness of not having a fulfilling relationship, which was sometimes accompanied by a sense of guilt. An unmarried woman in her thirties stated, "I start looking upon my aloneness as a handicap and a failure on my part. So that just adds to whatever I was depressed about." The three subjects who described their discomfort as being alone when one is "not supposed to be alone," may have been experiencing a similar sense of failure at not meeting personal or societal expectations.

Subjects cited several different reasons for the escalation of existing discomfort. One woman articulated a theme true for many;

that in general being alone made her "more conscious of the way I'm feeling." Another subject stated that

whatever mood I am in when I end up alone seems to exaggerate . . . I spiral myself into a worse state of mind, but if I am around other people and I just bounce off what is happening with them, I can usually see it in a much better perspective.

Another subject described his tendency to "blow insignificant problems out of proportion" when alone. The presence of others for some subjects could "get my mind off my personal problems," "break the spell" of depression, and "change the subject" as three other subjects put it. A young man who felt "afraid to be alone" reported, "I have a fear of becoming introspective." When asked what happened when he became introspective, he said, "More often than not I realize anger and sources of anger that I wouldn't realize without." Thinking about this anger was so "unbearable" for this subject, that he reported drinking heavily to block out the feelings (drinking until he passed out five nights a week). Subjects explained that having people nearby not only gave perspective or distracted them from negative feelings, but also provided feedback which served a reassuring function. Four subjects mentioned the "reinforcement" they needed from others when suffering poor self-esteem, and several subjects implied that others provided a calming effect when they were anxious. Two subjects noted that the presence of a "rational person" allowed them to think more logically, especially in cancelling illogical self-critical thinking such as "They don't love me; I'm a shitty person." Some subjects did

note that aloneness had no effect or was helpful in working through emotional upsets.

Magnification of depression. However, in the interview, 77% of the subjects suggested a relationship between physical aloneness and depression, by (1) describing their discomfort in aloneness as a depressed feeling, (2) describing intensification of depression occurring in physical isolation, and (3) noting that when depressed, they are likely to experience some other form of discomfort when alone, such as restlessness or anxiety. Forty-five percent described a "depressed," "sad," "down," "low," "sinking," "wistful" feeling as a type of discomfort experienced when alone. Sixty-eight percent of the subjects reported or implied that depression worsened or was prolonged in physical aloneness, with a comparable ratio of males to females to that existing in the overall study. As one subject put it, "depression would be disastrous" if alone, as there would be no way to "get out of it."

Fear of suicide. Eight subjects (14%) (7 females, 1 male) specified that a form of discomfort in aloneness stemmed from suicidal thoughts. One subjects articulated the fear that "There's nothing to stop me." Five of the subjects reported that suicidal thinking was an urgent signal to them to seek company. One woman noted that her despair ("What's the point?") was warded off by the ideas that she made her friends happy and they would be hurt if she killed herself. In addition, this young woman noted that "holding up a social front" was helpful to her.

Behavioral Responses to Discomfort in Aloneness

What do people do when they become uncomfortable in aloneness? How do they lessen or avoid distress? All but two subjects gave multiple responses; some distinguished different coping styles for different types of discomfort. The most common responses to discomfort involved seeking out friends or family members by telephoning or visiting, less selective social contact such as going out to be among people, seeking activity or stimulation, use of alcohol/drugs/food, and use of animals. In addition to some miscellaneous strategies, some subjects responded to discomfort by sleeping or sitting with the discomfort. Table 5 summarizes the most common responses to discomfort.

Social Contact

The most commonly given response to discomfort was that of seeking out a friend, neighbor, or family member to talk to, whether in person or on the telephone. Forty-eight subjects (86%) reported doing this in some instances of discomfort. These were considered direct, selective social contacts. Ten subjects described it as their primary, usual method of dealing with discomfort. Sometimes subjects noted that contact was important with a specific person (parents, best friend, sister, fiancée, therapist); sometimes subjects described talking with one of a group of friends, but "not just anyone."

All but one subject in the study had a telephone in his or her home; telephones seemed a very important connector to many of the

Table 5

Behavioral Responses to Discomfort

Response	Number of subjects (N = 56)	Number of low tolerance subjects (N = 14)	Number of high tolerance subjects (N = 7)
Selective social contact	48	11	5
Less selective social contact	29	6	4
Goes to mall, library, restaurant, bar, etc. to be among people	23	6	4
Phones "down a list"	4	1	0
"One night stands"	2	2	0
Hitch-hiking	1*	1*	0
Activity	41	11	3
Productive activity (study, work, housecleaning, cooking)	21	8	1
Creative projects	3	1	0
Exercise	11	1	1
Reading	19	5	2
Use of radio or television	34	10	3
Occasional use	10	0	3
Routine daily use	12	6	0
Constant use	12*	4*	0
Use of stereo	10	1	2
Going to movies	5	2	0
Driving	7	3	1
Use of alcohol/drugs	33*	9	2*
Mild to moderate use	18*	5	1
Heavy use	15*	4	1*
Eating	7	2	0
Without weight gain	3	0	0
With weight gain over 5 pounds	4*	1	0
Contact with pets	11*	4	1*
Sleeping	15	7	0
Sitting with discomfort	13*	5	3
Prayer/meditation	6	0	2
"Safety measures"	5	3	0
"Planning"	5	1	0
Writing in a journal	3	0	0
Writing letters	3	2	0
Taking a bath/shower	3	1	0
Masturbation	1	0	0
Physical contact with child	1	0	0
Breaking things	3*	1	0
Self-mutilation	2	1	0
Fantasy	2	1	0
Thinking of loved one, rereading letters	2	0	0

*Includes subjects describing past.

interviewees, especially those who lived alone and those living far from family. As one subject put it, "I would feel so totally isolated without that phone, it would be unreal." For others, who lived alone, neighbors were very important. A man noted, "If I didn't have my neighbors around, I think I'd go crazy." For most of the respondents, calling or visiting was a simple remedy, easily applied, especially for mild discomfort. For a minority of others, the decision to seek people was a difficult one, requiring great effort. One subject, who noted that being with people was much harder for her than being alone, said that there were times when she "should" be with others, but did not usually seek them out because of her fear of intruding on them and her apparent shyness. Another described her conflicts over seeking people out when she was depressed in the following statement: "I feel like I want to be with someone, like have them hold me or something, but I feel sort of guilty at the same time about telling someone my problems. So it's like, I want to call and then I don't." Two subjects explained that they were trying to achieve in therapy less tolerance for aloneness and a greater ability to derive support from others.

One subject, coping with a series of losses of important relationships: ". . . learned that there are different ways of meeting my needs. Before I thought I had to have close friends, buddies, a lover, but I've found you can keep yourself from lonesomeness with friends you know a little." For her and others, contacts which dispelled discomfort did not necessarily involve intimate or intense exchanges.

Twenty-nine subjects (52%) described less selective methods of achieving social contact. Twenty-three of these subjects noted that they have found themselves going out in order to be among people when they were uncomfortable being alone. Thus, these subjects would go to a shopping mall, restaurant, library, bar, or other public place for the experience of being near people, albeit strangers. Sometimes they might seek interactions; sometimes they might not. One subject described an example:

I got extremely upset over an argument that my husband and I had. And I took about 30-40 minutes to get myself to the point where I could stop crying, get things under control. I went to the student cafeteria and sat down . . . I didn't really consciously plan to talk to anyone. . . . But I went into the cafeteria and the place where I was sitting there was a guy who looked about my age so I started talking to him. We had a real nice conversation. And that was it. I doubt if I'll see him again . . . it was just a friendly conversation. And it really helped me to feel better.

For this woman alone of the 23 subjects, going out to be among others appeared to be her primary, usual way of dealing with discomfort exacerbated or created by aloneness. Interestingly, one woman reported a week long experiment in which she tried going to a bar after work, but found that she felt worse and did not continue to do so.

Four subjects, when queried, noted that if the person they wanted to talk to wasn't home, there had been times that they telephoned "down a list" until they reached someone. Two women mentioned that they had in the past picked up a relative stranger in a bar in order to avoid sleeping alone; one of these women had, as a teenager, hitch-hiked when she was afraid to be alone.

Activity

At least 41 subjects (73%) used activity as a way of dealing with discomfort. In addition, more subjects implied use of activity by saying that not being busy made discomfort worse. Twenty-one subjects described studying, working, housecleaning, cooking, or sewing to allay anxiety or depression when alone; three subjects discussed involving themselves in artistic activities when uncomfortable (poetry, painting, photography). Eleven subjects discussed the importance of exercise in "warding off panic," as one woman put it. Nineteen subjects specified reading as a way of coping. Two subjects specified that the book had to be "good"; two subjects specified light material as in magazines; one subject specified that the book had to be a "comedy book"; one subject specified frequently read books that were like "old pals," and one discussed restoring a sense of order by reading instruction manuals.

Use of Television/Radio/Stereo/Movies/ Driving

Use of a television or radio "for company" was described by 34 subjects (61%). A radio or television was on constantly for 9 subjects when they were home; three additional persons described past periods of constant use when they had televisions. A writer described needing the "white noise" of his radio to mask sounds of neighbors, but also referred to his radio music as a "security blanket," which "perked" him up to work. He reported that if his radio were to break, he would immediately get it fixed or buy a replacement. Other

subjects described their intense discomfort in a "quiet house," and had a radio or television on even when they didn't attend to it. Two of the constant users seemed ashamed and referred to their "addiction" to television, indicating that they watched a great deal of "trash." For 12 of the subjects, daily routine use of radio or television involved anywhere from one to five hours of viewing/listening. All but one of the constant and routine users saw their use of television/radio as at least at times a way of coping with aloneness. Ten subjects reported occasional use of television/radio to dispel discomfort, and allowed that they would watch a mediocre show on television. Ten subjects used a stereo regularly to change their moods. Five subjects (9%) mentioned going to the movies as a way of feeling better; seven subjects (13%) reported regularly taking a drive. Whether it is the stimulation or activity that driving offers was not clarified by the subjects, who noted that going for a drive took their minds off problems.

Alcohol/Drug Use

Some persons attempted to relieve their discomfort by using alcohol and or other drugs. Thirty-three subjects (59%) had tried alcohol/drug use for this purpose at one time or another, ranging from rare instances of drinking a little cognac or taking an antihistamine to sleep, to frequent episodes of intoxication to the point of passing out.

Eighteen subjects seemed to report mild to moderate use of alcohol and/or drugs; 15 subjects reported what the experimenter considered heavy use (drinking until drunk at least several times a month,

smoking 3 to 4 joints daily, or using "uppers" and "downers" on a daily basis). These numbers include three persons who reported mild to moderate alcohol/drug use in the past and six persons who had used heavily in the past. Again, one of the subjects described experimentation: "I remember having the idea years ago that if I drank a few drinks, it would fill the, you know, emptiness, but I found that it didn't work. So, I didn't use it that much."

Alcohol use seemed to be the current primary coping device for three of the heavy users. One subject reported that she was drinking "to replace contacts" as well as to reduce her shyness; another subject reported drinking in a bar with others could always make her feel good, although she viewed the drinking as problematic. One man who did not seek out others because he believed no one would want to hear from him, handled the unbearable awareness of anger which accompanied aloneness by drinking until he passed out five nights a week, in addition to monthly episodes of "self destructive use of drugs," including narcotics.

Eating

Seven subjects (all women) reported eating to dispel discomfort when alone. Four of the seven women noted that they had in the past overeaten to the extent that they gained over 5 pounds over a period of several weeks; two of these four subjects had weight gains of 20 pounds or more. One of these subjects had not been aware of the purpose of her eating until she kept records of the times of her

caloric "binging" and found that it was during the times of day when she was alone.

Pets

Eleven subjects discussed the importance of their pets (including two subjects to whom this applied in the past). A cat provided a woman "someone . . . always there, always waiting for you when you come home"; another woman noted the "unconditional affection" she received from her dog. The heaviest drinker described above who found it hard to seek out others stated: "As far as pulling me through periods of depression, talking to and/or relating to a cat nonverbally can do at least as much for me as talking to a person." A woman who had frequently felt betrayed or abandoned by people noted a similar effect:

If I wake up with something on my mind, like a certain chore I've got to do or an interview I'm dreading, . . . I for some reason imagine what it's like to see the world through their [the cats'] eyes. It really seems calm. Their life is so simple and filled with sleep and affection and now and then a little excitement like chasing mice. They don't intellectualize anything. That has a calming effect on me when I think about it . . . I'm more calm and productive when I have animals.

Sleep

Fifteen subjects (27%) mentioned that there were times when they were depressed due to aloneness, when they simply went to sleep to avoid the experience. This was a rare event for four subjects, but seemed to occur regularly for five subjects.

"Sitting With" Discomfort

Although it is probably true that all the subjects have "sat with" discomfort without doing anything on some occasions, 15 subjects (27%) articulated that this was a common response. Two subjects reported that in the past they "just felt awful," and did nothing to be with others. An additional five subjects painted this response in painful terms suggesting helplessness ("moping," "crying myself to sleep"). However, one man noted the importance of "paying attention" to the negative feelings to get through them, and four male subjects seemed to take pride in "riding it out" without doing anything. Several gave the sense that the discomfort could be "waited out" or "toughed out." For four of the subjects, "sitting out" discomfort seemed to be their most typical response.

Miscellaneous

The remaining miscellaneous categories of response involve fewer subjects. Prayer, reading religious books, and/or meditation were responses to discomfort for six persons (including one person describing past responses). Five subjects (all women) reported several types of "safety measures" to dispel fears of physical harm: two subjects got out of darkness; one subject stayed in the bedroom so she was invisible to passersby; one subject "plotted escape routes"; and one subject investigated noises while carrying her nunchakus (a martial arts weapon consisting of two heavy wooden sticks connected by a cord or chain), with which she slept. Life-planning (short-term and

long-term) seemed to be an activity that calmed five subjects when they became uncomfortable. Six subjects mentioned writing down their thoughts when others were not available to talk to (three subjects in journals, three subjects in letters). Three subjects mentioned relaxing by showering or bathing; one subject by masturbation; and one subject by physical contact with her preschool child. Three subjects reported breaking objects or smashing windows, and two discussed self-mutilation (for one woman, as a way to "discharge tension," for another, "causing physical pain or damage alleviates anxiety and the feeling that I don't exist"). Two subjects mentioned the importance of their rich fantasy lives ("Fantasy saved me," one said); and two subjects spoke of reviewing memories and mementos of loved ones as a means of feeling less alone.

From this listing, it should be clear to the reader that the subjects interviewed reported healthy and productive responses to uncomfortable alone experiences, as well as self-destructive responses: behaviors that pleased them, as well as behaviors of which they were ashamed. No checklist was given, so the list is probably not complete. In addition, most subjects reported multiple responses, and there was not always a usual approach defined. Nevertheless, it appears that subjects most often seek companionship, solace, and stimulation from known others; from strangers; from activity; from books, music, television, movies, scenery; from animals; from auto-erotic stimulation; and from use of sedatives/stimulants. Subjects reported experimentation in trying different behavioral responses, and dropping unsuccessful coping methods.

Factors Aggravating Discomfort

Subjects spontaneously offered the experimenter many reasons that discomfort occurred during some alone times, yet not at others. A small number of subjects described little or no discomfort in aloneness in their current lives, yet could point to stressful periods during which time aloneness had been uncomfortable. With the exceptions of inquiries about the effects of existing moods on the alone experience, these stressors were not brought up by the examiner in the interview. Thus, they clearly spring from the subjects' experiences and understandings of experience. However, when reviewing the numbers of subjects who reported each stressor, one must recall that subjects were not queried about each condition. For example, only 14% of the subjects articulated that self-esteem affected tolerance of aloneness; this does not mean that the remaining subjects' tolerance of aloneness was not also affected by periods of poor self-esteem, only that they did not bring up this issue in a direct way.

It is apparent from the interviews that tolerance of aloneness is not simply a constant, unchanging trait. It is influenced by moods, self-perceptions, actions, and circumstances. Some subjects reported that their tolerance of aloneness had changed in the course of psychotherapy through their conscious efforts. Some of the factors which seemed to cause or aggravate discomfort in aloneness are listed below: unavailability or loss of relationships/unchosen aloneness, stresses in existing relationships, physical threat, "unavailability" of activity,

moods, and other pressures. Table 6 indicates the number of subjects indicating these aggravating factors.

Unavailability or Loss of Relationships/
Unchosen Aloneness

Choosing time to be alone in order to think, relax, or get things done seemed to have universal value. Many subjects described their most painful experiences in aloneness as occurring when they did not choose to be alone. It "happened" to them by virtue of a variety of circumstances, notably those which made relationships less available. Although unchosen aloneness was not necessarily problematic, it seemed to be a condition which aggravated discomfort for a majority of subjects. Thirty-six subjects (64%) stated or implied that the issue of choice was an important factor in determining comfort versus discomfort in aloneness. One young man noted the perverse experience, "If I can't be with someone, I feel like I need to." Several life experiences as stressors were discussed which led to temporary periods in which relationships were made less available, leading to the uncomfortable experience of unchosen aloneness. These were: physical distance from trusted others, divorce/break-ups (which also involved other factors), temporary separations, scheduling difficulties, and solitary confinement.

Physical distance from significant others. One factor which made close relationships unavailable was physical distance. One of the stresses of a mobile society is its disruption of ties with families, friends, and lovers; this disruption, in turn, seemed to escalate

Table 6

Factors Aggravating Discomfort

Factors	Number of subjects
Physical distance from trusted people	
Move to new city	5
Move from boyfriend or girlfriend	3
Move from family	2
Living or traveling in foreign country	2
Culturally different, no one to trust	3
Friends moved	4
Distance from "people to help me"	3
Loss of relationship	
Divorce	7
Breakup with boyfriend/girlfriend	8
Multiple losses	2
Schedule	2
Forced confinement	2
Threat	
Rape	2
Physical threat	3
Robbery	2
Communication problems or problems in existing relationships	
Problems with a lover	6
Conflicts or inadequate communication with parents	3
"Cultural" differences leading to communication problems	9
Illness	3
Other pressures	
Out of "good" work	2
School pressures	5
Relationship with God	2
Low self-esteem	8
Existing moods	
Depression intensified or prolonged	40
Anger worsened	18
Anxiety worsened	25

discomfort related to physical aloneness. Of the 56 subjects interviewed, this type of stress had effected 15 subjects (27%). Five had experienced discomfort accompanying a move to a new city (this included two persons who held temporary posts in new cities). A woman experienced depression and discomfort in aloneness after her move across the country to return to school. Before her move, she had the "support systems arranged" through her work, and stated that when she was alone:

I didn't feel depressed. You know, after I worked I pretty much did what I wanted to do; usually at night . . . I was at home by myself and that is what I preferred after being with people all day . . . it was easier for me to be alone I guess because I had all my needs met. Before it was more like a choice to be alone, whereas here I don't know if I have that much of a choice. When I freely choose it, it is easier to enjoy.

Up until her move, this woman seemed to have thought of herself as someone who liked to be alone.

Three subjects had specified as stressful their long-distance romances with lovers living in different cities. A male student who had moved away from his family and girlfriend in order to attend school described times when "I literally lose sleep over it [being alone]." He said that communication problems and fights in his long-distance relationship were doubly upsetting because "there was nobody I could talk to. Nobody really understood my situation . . . sometimes I feel being a Northerner down here, I felt alone and there weren't that many people I felt I could trust to help me."

Four subjects reported the impact of close friends moving to different cities, limiting their contact. Two subjects found moving

from their families to a college campus stressful; two subjects from foreign countries and one subject from a distant part of the country noted that their situation was made difficult by the distance from their families and from trusted others generally; even travel in a foreign country was described as increasing loneliness by one subject. Their sentiments echoed those of the Northerner who felt he had no one to trust with problems.

On a much smaller scale of distance, three subjects noted discomfort stemming from being in a big house or one in a rural area, far from neighbors or "people to help me."

Divorce, break-ups, and other losses of relationships. Seven of the 12 divorced subjects described their divorces as periods of added discomfort in aloneness, and 8 subjects reported painful aloneness experiences following break-ups with boyfriends or girlfriends. An additional 2 subjects pointed to multiple losses of relationships as a cause for discomfort: the holiday following a divorce when friends were out of town for one, and for another, broken ties with a friend coinciding with a break-up and with her older sister's marriage. Thus, a total of 17 subjects (30%) expressed relationship losses as aggravating discomfort in aloneness.

Unavailability of the relationship seemed to be only one of several reasons for the discomfort. For instance, several subjects mentioned that they had "gotten used to" living with a person or family, and had to adjust to a new experience. One woman repeatedly used the word "unnatural" to describe her experience. Several subjects described

break-ups/divorces in terms of rejection. A woman remembers her lover "out of the clear blue sky" asking her to move out:

I was shattered; my world was shattered. . . . Besides the fact that I felt worthless, I felt rejected; I felt that I could do nothing that was right or good; I hated myself and I hated him. I didn't get much comfort out of anything I did.

In this case the rejection caused self-esteem problems, which seemed to make aloneness extremely uncomfortable. There is often a sense of failure in the ending of a relationship, as well as subtle changes in self-image. A woman who suffered the stress of separation and divorce in the context of a recent move to a city where she had no friends felt that before her divorce:

Time alone was quality time; . . . I felt more productive; I had more choice about it . . . I didn't feel I was alone. I was attached to someone with the understanding I would be alone a certain amount of time. I didn't feel like I really was [alone]. I was an extension of someone, of a relationship. I don't know how to explain it. Now it's more like I know that I am more or less by myself. I don't have family to fall back on. I don't have very many long-term relationships; most of the people I know are new people. I guess I don't feel I'm linked to a relationship or I'm an extension of someone.

She expressed the notion that her identity had been limited somehow, in addition to the factor of having no choice and of having no time limits to her aloneness. Another woman noted her awkwardness at suddenly having only her own needs to worry about. Having focused on family members, she stated specifically, "I do not like being single." Her loss of tolerance for aloneness had been a constant for the 10 months since the divorce; she found she was unable to concentrate well enough to read a book. A male describing the "depressing

lonely time" after his wife left, said that it only lasted a month. At that point, he responded to the "timely" invitation of his friends to move in with them:

I was getting that panicky feeling . . . coming on at night when being in the apartment was really sad. And I was sort of avoiding seeing people at that point. I probably would have gone back to drinking or drugs . . . , to curb those feelings, but I realized I needed to move in with somebody . . . so it sort of saved me.

For other subjects as well, the sudden, unaccustomed aloneness allowed them to "dwell on" negative feelings. It is interesting that some of the divorced subjects did not describe their divorces as stressors of their capacity to be alone. Several respondents noted their relief to be alone, and some seemed proud of having taken action. One divorced woman, who had a four day period of feeling "emptiness" and "disconnectedness" following separation stated, "For years I was afraid of living by myself, afraid I'd be lonely. But when I actually started living by myself, I discovered that wasn't the case at all." She found "I can amuse myself and I like myself. So of course, I don't mind being alone with someone I like."

Temporary separations. Seven subjects (13%) mentioned for the most part mild discomfort occurring when significant others were temporarily absent from home. For two subjects, the significant factor was the degree to which the separation was expected and planned for. The one subject of this group who experienced more disturbing feelings ("confusing and hectic," "anxious and fearful") felt that aloneness was only a burden when it was "thrown at" her unexpectedly.

When this happened, she felt "compelled to plan something." There was a sense of "What can I do?" of having to "fill up" time, of fear of physical threat, and of impaired concentration. The effects of unexpected alone time were multiplied if she were tired or not feeling positive about herself.

Scheduling difficulties. Because he worked the night shift (and did not choose to socialize with coworkers), one man experienced a great deal of unchosen alone time because his schedule did not mesh with his friends' schedules and he could find few activities available after work. He, as well as a male subject who only required 4-5 hours of sleep/night, frequently found alone time at night frustrating in that it was not chosen.

Solitary confinement. Two subjects mentioned their extreme discomfort in experiencing the ultimate in unchosen aloneness: being locked in a solitary room. While other factors (loss of control, claustrophobia, etc.) may have played a role, both the subject who experienced solitary confinement in jail and the subject who was locked in a mental hospital solitary room, described feeling frantic to get out and be with others.

Stresses in Existing Relationships

Pressures stemming from problems in existing relationships escalated discomfort for 18 subjects (32%). Included here are subjects experiencing communication problems with a spouse/lover, with parents, and with peer groups at work or school.

Problems in relationships with spouse/lover. Six subjects, all women, described poor relationships as causing intolerance of aloneness. Three subjects described relationships with abusive or insensitive men; two subjects described relationships with uncommunicative men; one subject described her unhealthy dependence on an adequate man. With the exception of the last mentioned woman, these subjects experienced a sense of isolation triggered by feelings of not being understood or valued by their partners. The isolation and negative valuations of self seemed exaggerated in physical aloneness. One woman said:

The last time I had a problem being alone was because I thought I was going to stay alone forever. I was dating someone who drank a lot and kept promising he'd visit or call, and he never would. I was scared that everybody was going to lie to me, that I was never going to have anybody again. That's scary!

This woman, who reported complete comfort in aloneness at the time of the interview, experienced frenzied agitation (pacing, crying, "drinking just to stay calm") at the time of the described relationship, for periods lasting up to 6 hours. Two of the women described their relationships as overdependent, based on their needs for approval and reinforcement in order to feel good about themselves. Often, these subjects focused on their relationships when alone, which seemed to add to "frustration," "alienation," and bad self-feeling.

Conflicts or inadequate communication with parents. Four subjects described inadequate communication with parents which enhanced a sense of isolation and "not belonging." Two of the subjects lived with their parents, and found themselves unable to talk to them.

Differences with peer groups leading to communication problems.

Ten subjects described feeling different from their peer groups at school or work for various reasons, and thus unable to communicate fully. Two subjects were foreign students with different language and cultural background; two subjects were lesbians ("being gay is lonely in itself"); one subject described an "off-putting" position of authority in her dormitory; one subject was a northern Catholic living in the South; one subject felt isolated from her peers by virtue of her divorce; two subjects described "not fitting in" at school; one subject felt isolated by his intellectual superiority; and one subject felt different from her church group in unclear ways. These experiences of differentness led to inadequate peer relations, and a resulting sense of isolation which carried over to their experience of physical aloneness.

Physical Threat as a Stressor

Six subjects (11%), all women, mentioned that their experiences of rape, robbery, or physical threat caused them to feel unsafe sometimes when they were alone. The two women who were raped seemed "haunted" by the experience, as one of the women put it, although the rapes occurred 13 and 5 years in the past. It caused them a fearfulness and uneasiness at times when they were physically isolated. One of the rape victims was later the victim of a robbery, which increased her fears, especially in the weeks following the robbery. Other subjects mentioning more temporary reactions of fear were victims of robbery, of physical threats from an ex-husband, intrusion by

unwelcome male acquaintances visiting her apartment and "invading body space," and of an attempted break-in.

Unstructured Time

When "not busy," 23 subjects (41%) reported greater discomfort in aloneness. When between projects, when unable to concentrate on an activity, when many activities were unavailable as during the middle of the night, these subjects tended to report greater anxiety or other discomfort. Interestingly, when subjects specified times of greatest discomfort, they mentioned night-time and weekends, and especially week-end nights. One woman said specifically that this is because "It's harder to be busy at night." (This finding may also be explained by night-time fears of the dark or of crime, and by social pressures to be dating.)

Although some subjects described their comfort in daydreaming, meditating, "reaffirmation of personal values," or simple relaxation, periods of inactivity during aloneness were intolerable to other subjects. When one subject was asked, "What if you were to be alone and not busy," she replied seriously, "I would go crazy."

Moods

Eight subjects (14%) clearly spelled out a relationship between self-esteem issues and comfort in aloneness. Seven out of the eight subjects were women. As one said, "If I'm not feeling positive about myself, it affects it [my experience of aloneness] very adversely. It intensifies it definitely. If I'm feeling positive about myself, I accept it as a special time."

Three subjects reported that before experiencing a period of living alone, they felt "unconfident," "dependent," "afraid of being lonely," and "like I couldn't take care of myself." One subject said, "Living alone and surviving: it felt good. I needed to prove I could." The subjects in this situation all felt initial discomfort in leaving a relationship and in their reactions to aloneness, but felt positive about aloneness being a learning experience, "an eye-opener." Periods of poor self-esteem seemed to lead to discomfort for many other subjects who did not articulate this as a factor.

Subjects were asked specifically about the effects of their moods on their experiences of aloneness. When asked about the effect of an existing depressed mood on aloneness, a majority of subjects (59%) reported that their depression was prolonged by aloneness; an additional 9% said that they would seek out others if depressed and alone, implying that depression worsened with aloneness. Eleven subjects (20%) reported no consistent effect of aloneness on depression; seven subjects (13%) reported that their mood would improve given alone time.

When asked about the effects of physical aloneness on anger, 16 subjects (29%) stated that they would seek out aloneness in response to anger. An additional 16% articulated clearly that aloneness calmed them down or aided in expression (and timing of expression) of anger. However, for 27%, anger either turned into depression or grew worse by "simmering" with physical isolation; an additional 5% implied this by describing their tendency to seek out others. Thirteen subjects (23%) described no consistent effect of aloneness upon anger.

When asked about the effect of aloneness upon anxiety or worry, 20 subjects (36%) reported that the anxiety worsened and an additional 7% implied this by saying they would seek out others. Only two subjects (4%) stated and three subjects (5%) implied that anxiety improved or lessened with aloneness. Forty-three percent of the subjects (24) reported no consistent effect on anxiety.

When asked about the effect of aloneness on a good mood, 12 subjects (21%) noted that their mood might be dampened or "brought down." The remaining 79% reported no effects.

Thus, a majority of subjects (68%) reported or implied that depression intensified or was prolonged when they were alone; 32% reported or implied that anger was worsened when they were alone; 43% reported or implied that anxiety was intensified when they were alone; and 21% reported that a good mood was dampened by aloneness. Clearly, depression can stress tolerance of aloneness, and for some subjects, anger, anxiety, and poor self-esteem can exaggerate or cause discomfort in aloneness.

Other Pressures

Subjects mentioned a variety of other factors aggravating discomfort. Five subjects reported discomfort in aloneness as occurring predictably when school pressures mounted, near the end of a quarter, or during periods in which they were having difficulty structuring time. Two subjects mentioned the stresses of not having a full-time "good" job. One said she "climbed the walls" during her off days; the other subject described his shame at failing to get a job in

his field and his anger at working under the authority of persons with less intelligence and education than he had, feelings which seemed to aggravate discomfort in aloneness.

Two subjects mentioned periods of sickness as times during which they could not tolerate aloneness; a third subject, who thought of his "dark periods" as manic/depressive episodes, might also fit in this category. Two other subjects who discussed physical illness, however, reported that they wanted to be alone when ill. One noted the "contagion" of pain and her discomfort in dependency; one noted her symptom of irritability.

Struggles in a relationship with God seemed to stress alone experiences for two subjects. A woman talked of philosophical aloneness as the notion that "each one of us is so different," with unique experiences and circumstances which others cannot "really comprehend." She felt that this sense of aloneness:

. . . is sometimes overwhelming. . . . I guess it depends on how I am feeling in terms of God. . . . My personal connection with him is just about directly related to the moods I am in. When I am really, really depressed and I pray and reach out to God, sometimes I do not feel his or its presence and I feel very alone. At other times, I feel connected; I feel . . . there is a purpose here, . . . that kind of feeling of connectedness and importance; my purpose, my being having importance and purpose. That is a very creative, positive feeling for me, but my moods alter how I perceive the whole situation. Sometimes I feel very connected and sometimes I feel totally cut off from people and from God. It is not a constant thing; my faith is not constant.

A man who had studied to be a priest noted that he at times felt "spiritually alone" and "couldn't even express or share" what he "was struggling with." He felt that spiritual "contact with one's deepest

self," with different aspects of oneself, with God, had the paradoxical result of a sense of harmony, of being "in touch with others." Difficulty accepting his own needs/feelings or "spiritual depletion" seemed to be the cause of despair and loneliness: "lack of harmony, confusion, doubt, a whirlwind to be waited out." For this man, "running from" discomfort exacerbated it, and for him "the spiritual path" was the best means of coping with isolation, confusion, and desperate loneliness.

Other Interview Data

"Semi-aloneness"

To get at the concept of "alone but together," the experimenter asked if subjects found "semi-aloneness" valuable, i.e., did they find it valuable to, for example, sit in the same room as another person without interacting, each involved in his or her own activity. Sixty-one percent of subjects reported they found this state valuable for a variety of reasons; the remainder did not find it valuable, preferring either complete aloneness as less distracting or preferring interaction when with another. Reasons given for enjoying "semi-aloneness" were most often put rather vaguely: "It's just nice to know someone's there" (six subjects) or "If I want to talk, I can" (4 subjects). In addition, a feeling of increasing safety of self or others was described by seven subjects: three subjects valued having the choice to interact ("It's like having your cake and eating it too"); six subjects stated that semi-aloneness helped their studying; three subjects reported it made them feel less lonely or depressed, or more content and stable.

Unaccompanied Outings

Fifty-two subjects of the 56 were asked if they had attended movies or restaurants unaccompanied. (Unfortunately, the experimenter neglected to ask this question of four subjects.) Thirty-nine of the 52 subjects (70%) had attended a movie alone, but this included one subject who had done so once, four subjects who did so in the past, and four subjects who reported that they did so infrequently. Of the 13 subjects who had never gone to a movie unaccompanied, 69% were female (comparable to the overall percentage of 66% females). Seventy-one percent of the subjects had gone to a restaurant unaccompanied (including one subject in the past, one subject who had done so once, and three subjects who did so on rare occasions). Fifty-eight percent of the subjects who had never been to a restaurant unaccompanied were female.

Rating Tolerance of Aloneness

Review of Selection Procedure

To review the selection procedure for the two experimental groups, ratings of tolerance of aloneness were made by the experimenter and an experienced clinical social worker on the first 36 subjects, based on their interview transcripts. At this point, four subjects were ruled out because of disagreement between the two raters.

Therapists of the subjects were asked to make ratings or indicate that they had insufficient information to do so. Subjects were ruled

out when therapists and raters disagreed (18 subjects), but not when therapists indicated that they had insufficient information, which occurred in 11 cases (20%). Due to high interrater reliability between the experimenter and the rater, the experimenter alone rated the remaining 20 subjects, along with a therapist (when the therapist had sufficient information).

All subjects rated as having average tolerance of aloneness by either rater or therapist were not selected. This included nine subjects in which raters and therapists agreed that a subject had average tolerance of aloneness, 10 subjects in which a therapist indicated average tolerance (in 3 of these 10 cases, one of the raters also indicated average tolerance), and 3 additional cases in which a rater indicated average tolerance of aloneness. Thus 22 subjects of the 56 subjects were ruled out because they had one or more rating of average tolerance. An additional 7 subjects were ruled out because therapists and raters gave opposite ratings (2 cases in which a therapist rated low tolerance and a rater indicated high tolerance, and 5 cases in which a therapist rated high tolerance and a rater indicated low tolerance). Of the 27 subjects remaining, 19 subjects were selected in the low tolerance of aloneness groups, and 8 subjects were selected for the high tolerance group. However, even after efforts to contact subjects, five of the low tolerance subjects could not be "tracked down" and one of the high tolerance subjects decided against participation due to time demands of his business. This left 14 low tolerance subjects and 7 high tolerance subjects who participated in the experiment.

Reliability of Ratings

With training and discussion of samples, tolerance of aloneness evident in the interviews could be rated reliably. Two raters, the experimenter and an experienced clinical social worker, agreed in 89% of the 36 interviews both rated. Ratings of therapists provide some validation of the rating scale, although agreement between therapists and raters was not nearly as predictable as that between raters. Rater 1 agreed with therapists in 74% of the 27 cases which both Rater 1 and a therapist rated. The experimenter agreed with therapists in only 60% of the 45 cases rated by both she and the therapists.

Analysis of Disagreements

Several factors may account for the difference in interrater reliability and rater-therapist reliability. First, raters worked from interview data; therapists made their judgments on the basis of available clinical information. One would not expect perfect agreement, given the different sources of information. Second, therapists seemed to rate differently in a systematic fashion. Table 7 shows that, compared to raters, therapists rated a greater percentage of subjects as having average tolerance of aloneness and a smaller percentage of subjects as having low tolerance. The experimenter was most free in rating subjects as having low tolerance, and in fact, labeled five subjects low tolerance whom therapists rated as high tolerance (see Table 8). Table 9 shows better agreement between Rater 1 and the therapist. Table 10 illustrates the excellent agreement between the two raters.

Table 7

Percentage of the Ratings of Tolerance of Aloneness Made by Therapists, Rater 1, and Rater 2 (Experimenter)

Tolerance	Therapists*	Rater 1	Rater 2
Low	35.6	50.0	57.1
Average	42.2	27.8	19.6
High	22.2	22.2	23.2

*Eleven of 56 subjects (19.6%) were not rated by therapists due to insufficient information.

Table 8

Agreement Between Therapists and Rater 2 (Experimenter)

Rater 2's rating of tolerance	Therapist's rating of tolerance		
	Low	Average	High
Low	14	7	5
Average	0	9	1
High	2	3	4

Table 9

Agreement Between Therapists and Rater 1

Rater 1's rating of tolerance	Therapist's rating of tolerance		
	Low	Average	High
Low	9	5	0
Average	0	9	0
High	1	1	2

Table 10

Agreement Between Rater 1 and Rater 2 (Experimenter)

Rater 1's rating of tolerance	Rater 2's rating of tolerance		
	Low	Average	High
Low	18	0	0
Average	3	7	0
High	1	0	7

A look at the subjects who were rated high in one judgement and low in another points to some of the difficulties in rating tolerance of aloneness (and in considering it a trait). The 7 subjects with disparate ratings were similar in that either their work was performed (comfortably) in physical isolation, or in the case of the two students in this category, they spent well over the average number of hours in physical isolation (58-65 hours, 77 hours). Thus, there were indications that these subjects chose or tolerated physical aloneness. The contradictions embodied in the 7 subjects rated disparately were striking in the interview. For example, a writer (A) who spent an average of 108 hours/week alone reported that his aloneness was comfortable (far more comfortable than being with others), but not good for him, either as a person or a writer. Another writer (B) spent 54 hours/week alone, chose not to own a telephone, seemed very comfortable in physical aloneness, except when he experienced "dark periods" he believed were manic-depressive episodes, during which time he was agitated, feared suicide, and felt extremely isolated and

unhappy in aloneness. Similarly, a young woman (C) preferred aloneness in most instances, spending 77 hours/week in aloneness. She felt more relaxed and comfortable in aloneness, unless she experienced depersonalization ("like I no longer exist"). At those relatively rare times, she "had to be with others, or else." Interacting with another person seemed urgently needed in order to regain her sense of self. She sometimes used self-mutilation to make her feel a "me-ness." A young woman (D) who lived with her parents yet spent 35-40 hours/week alone, had a job which involved physical isolation most of the day. She described aloneness as resulting in her "highest highs and lowest lows." For the most part, she described her relationships with people as hurtful or tension-arousing and she preferred her "own reality." However, her isolation was at the same time extremely painful to her, leading to suicidal fantasies and panicky feelings she was able to ward off with exercise. A rather naive 18 year old male (E) who noted that he had no friends and did not know how to make friends bemoaned his very painful loneliness, which was often accompanied by insomnia, nausea, impaired concentration, "chills and shivers." Nevertheless, he spent 58-65 hours/week alone and passed up opportunities to interact with others. Another woman (F) reported difficulty being able to talk meaningfully to others, but seemed happy to work alone and vacation alone. However, when involved in a relationship, she reported a pattern in which she became dependent, had to be with her partner in order to get a "stamp of approval," was quite anxious about the relationship's survival when alone, and lost her

usual ability to take comfort in solitary activities. One male (G) worked at multiple jobs and hobbies which provided for indirect interaction with others (telephone contact, radio communication, etc.) and had limited direct interaction with his family or others, as their conflicting schedules rarely allowed it. He reported little discomfort in aloneness in the interview.

From the brief summaries above, it appears that in some cases (B, C, D, F), aloneness is for the most part preferred but can be extremely uncomfortable under certain circumstances. A and E presented a rather isolated lifestyle which caused A an intellectualized awareness that it was "unhealthy" and caused E acute distress. All these subjects (especially A, C, D, F, and G) were viewed as somehow having schizoid conflicts in which there were difficulties in talking to others, in forming or maintaining close relationships. Fears of engulfment or intrusion typical in schizoid conflicts lead to discomfort in being with people, and often, to the choice of spending time in physical isolation. However, there may be great discomfort in the aloneness, which may be tolerated rather than risking the anxieties associated with interaction. These issues, which allow a subject to prefer aloneness and yet to be significantly discomforted by it, caused some difficulties in making ratings. The list of subjects ruled out for selection due to disagreements between raters or therapists seemed to the experimenter to be predominately composed of subjects coping with schizoid issues. Fourteen of the 18 subjects ruled out due to disagreements (78%) were viewed by the experimenter as either clear-cut

cases of schizoid pathology (5 subjects--28%), or cases involving schizoid elements (9 subjects--64%). Twenty-eight percent of these 18 subjects stated specifically that being with people was more uncomfortable than being alone and 22% spontaneously described histories of isolation during childhood.

The raters came to a decision to rate a subject as having low tolerance of aloneness when they described within the past two years extremely painful experiences of aloneness with urgent or frantic needs to be with others or to be otherwise stimulated, especially when they described self-destructive defensive/coping responses. The frequency, extenuating circumstances, and usual valuation of alone times were given little consideration. Therapists, without benefit of discussion/training sessions, were probably more likely to give average ratings which may have been a way of dealing with conflicting data, to rate on the basis of the subject's usual response to aloneness, to confuse preference with tolerance, and to use their own biases and understandings of priorities in making ratings. On a few occasions, therapists neglected clear indications of symptoms of low tolerance of aloneness, such as self-mutilation or panic, perhaps due to the amount of time a subject spent in aloneness or his or her stated preference for aloneness.

Composition of Selected Subject Groups

Eight subjects with high tolerance of aloneness and 19 subjects with low tolerance of aloneness were selected. Of these, 7 high

tolerance subjects and 14 low tolerance subjects participated in the second part of the study. Drop-outs were subjects who changed names, addresses, or phone numbers and could not be "tracked down," plus one who decided not to participate. The high tolerance group contained 71% females (comparable to the 66% figure for the overall study) and had a mean age of 29 years (compared to 27 years overall). None of the high tolerance subjects lived alone, although 43% were single. Forty-three percent of the subjects lived with roommates or housemates; 14% lived with parents; 43% lived with a spouse and children. Forty-three percent of the high tolerance subjects were married with children; 43% were single, and 14% were divorced. The average number of hours spent alone per week was 23.

The subjects composing the low tolerance group were 78% female (a slightly higher percentage than the overall percentage), and had a mean age of 27. Twenty-nine percent lived alone; 29% lived with parents; 14% lived with a spouse or lover; 7% with a child; and 21% with roommates. Sixty-four percent were single (compared to 64% overall and 43% of the high tolerance group); 36% were divorced (compared to 21% overall and 14% of the high tolerance group); 7% were married (compared to 14% overall and 43% of the high tolerance group). The average number of hours spent alone per week was 36 hours. Table 11 presents percentages for the two groups and for the total sample.

The low tolerance group identified more sources of stress than did the high tolerance group. Seven of the 14 low tolerance subjects

Table 11

Comparison of Composition of Low Tolerance Group, High Tolerance Group, and Total Sample

	Percentages of groups		
	Low tolerance	High tolerance	Total sample
Females	78	71	66
Males	22	29	34
Living alone	29	0	23
Living with roommates/housemates	21	43	32
Living with parents	29	14	13
Living with spouse/lover or spouse/lover and children	14	43	27
Living with child or other	7		5
Single	64	43	64
Married	7	43	14
Divorced	36	14	21
Have children	14	43	16

had experienced a divorce or significant break-up within the year, which for three subjects had meant suddenly living alone for the first time in years. None of the high tolerance group had experienced a recent divorce, separation, or break-up. Other stressful circumstances described by the low tolerance subjects included: rape in two cases (one of whom also suffered a later robbery), long distance moves in three cases (with one subject moving from a foreign country, and one subject carrying on a long-distance romance). One of the two low tolerance subjects who identified themselves as gay mentioned gayness as a stressor; one subject was out of a steady job; one subject was experiencing difficulties in a relationship with a lover (this subject had also been physically threatened by her ex-husband); and two subjects were experiencing conflicts with parents. Twelve out of 14 low tolerance subjects complained of a significant current source of stress.

High tolerance subjects mentioned the following stressors: a past divorce which had short-term effects, a current relationship with a spouse, an attempted break-in, past spiritual struggles, and for two subjects, having close friends move away. Only 3 of the 7 subjects identified current stresses, and these were not the multiple major difficulties that applied to several of the low tolerance subjects.

Analysis of Object Relations Technique Responses

Reliability of Scales

Because the Object Relations Technique evoked many stories which could not be scored (or scored meaningfully) by the Krohn

Object Representation Scale for Dreams, the researcher developed six scales, designed to measure different facets of object representation development, in a rather concrete manner. These scales are included in Appendix F. The first scale, a 4-point scale, was designed to measure the degree of projection and enlivenment evident in the story. The two independent raters did not score a single production as a "0" or card description; thus the scale became a 3-point scale which ranged from (1) minimal enlivenment, action or explanation of motivation to (3) involved, detailed projection. Raters agreed exactly in 78% of the cases. The second scale measured character description on a 4-point scale, in which a "0" indicated no characters, a "1" indicated that the subject had described the character(s) simply as "person" or "male" or "female," a "2" indicated a role description or a single description with "person," and "3" indicated further description, tending toward multidimensional description. Exact agreement between raters on this scale was 90%.

A 3-point scale was used to measure description of physical setting ranging from no description, to a brief factual statement, to further description; agreement on ratings for this scale was 85%. Judges agreed the least (71%) on a 4-point scale measuring degree and complexity of interaction (where "0" stood for no interaction, "1" for parallel activity or comments on lack of fulfilling interaction, "2" for stereotypic interaction, and "3" for complexity in presenting feelings and conflicts behind interactions). Valence of interactions was measured on a 5-point scale ("2" was clearly malevolent or threatening;

"-1" indicated a sense of negative or unfulfilled interaction; "0" showed neutral interaction or no interaction, "+1" scored a sense of positive interaction, and "+2" was for stories with distinctly positive, nurturing, loving interactions). Raters agreed exactly in 84% of the stories on rating valence of interaction. Valence of physical environment, also a 5-point scale, worked in a similar manner. Judges agreed on these ratings in 93% of the ratings.

Rather than use Krohn's complex scale, it was decided to rate the scales on much cruder, simpler scales, and to measure description and valence separately for both environment and characters. Measures of description levels and valence were quite reliable (84%-94%). Degree of projection and degree/complexity of interaction were more complex concepts, and had slightly lower interrater reliability (78% and 71%).

Comparison of High Tolerance and Low Tolerance Groups

Ratings on the 10 stories were averaged for each subject. Mean ratings for each subject were averaged for the low tolerance group and the high tolerance group; the valence ratings were given a mean positive and mean negative score. The resulting mean scores are presented in Table 12. Significant differences between groups in the Object Relations Technique story ratings were not found for any of the six scales. While the high tolerance group scores had slightly higher means of positive valences (for both interaction and environment) and slightly lower means of negative valence, these differences were not found to be significant when analyzed by a chi-square format comparing the number of subjects scoring over the total mean with the

Table 12

Mean Ratings of Object Relations Technique Data

	Low tolerance group	High tolerance group
Degree of projection	2.20	2.33
Character description	1.70	1.67
Physical setting description	1.28	1.39
Degree/complexity of interaction	1.42	1.33
Valence of interaction	+2.64/-2.29	+3.29/-2.00
Valence of environment	+1.21/-1.36	+1.57/-1.29

number of subjects scoring below the total mean. For the first scale (degree of projection), the chi-square was computed at .02; for the character description scale, the chi-square was computed at .22; for the scale measuring the degree of description of the physical setting, the chi-square value was .03; for the degree of complexity scale, the chi-square value was .22. The chi-square mean for positive valence scores on interaction was .02; for negative interaction scores, the chi-square was .67. The positive valence scores on the environment were compared in a chi-square of .025, and the negative valence of environment scores were computed in a chi-square value of .22. (To be significant at a .05 level, the chi-square value should have been 3.891 at least.)

In addition to comparing scores on the six scales, the number of words per story was counted and averaged for subjects and then for groups. The high tolerance group told longer stories, with a mean story length of 107 words. Low tolerance group subjects told stories

which had mean of 86 words. The Mann U statistic, using rankings of the mean number of words per subject, was computed to be 65, significant at greater than the .001 level of probability.

Analysis of Dreams and Early Memories

Review of Scoring Method

Dreams and early memories were collected, typed, and placed in a random order (except when a subject's interpretive comments followed a series of dreams). Two judges, advanced clinical graduate students well versed in object relations theory, studied the training material written by Krohn (1974) included in Appendix A. They then practiced with the experimenter on hundreds of sample dreams and memories, and discussed the scorings. Telephone communications with Krohn (April 20, 1985; May 2, 1985; June 14, 1985) were made by the experimenter to find out how he would score some difficult productions. The judges scored the actual data independently in six portions, meeting and discussing disagreements after each portion. In every case in which judges disagreed, they reread the dream or memory and came to an agreement by consensus. The agreed-upon scores were then analyzed.

Reliability

The dreams and early memories collected from the experimental subjects were rated on Krohn's Object Representation Scale for Dreams. This is an 8-point scale included in Appendix A. The two

raters agreed exactly on 54% of the productions, but their scores were within one scale point of one another on 81% of the items.

Table 13 compares the interrater reliability figures with those obtained by Krohn and Mayman (1974). The raters in this study were in exact agreement on scores for early memories only 46% of the time, but were within one point of each other's ratings 84% of the time. For dreams, raters agreed exactly in 59% of the cases, and were only one scale score "off" in 79% of the ratings. Reliability figures are comparable to those calculated by Krohn and Mayman, although for the early memories the raters in this study achieved fewer instances of exact agreement, but more instances of agreement within a scale point than their counterparts in the Krohn and Mayman research.

Table 13

Interrater Reliabilities for Dreams and Early Memories: Comparison of Present Findings with Results of Krohn and Mayman (1974)

	Percentage of exact agreement		Percentage of agreement within 1 scale point	
Early Memories Test	46	67*	84	74*
Dreams	59	58*	79	83*

*Reliabilities found by Krohn and Mayman (1974).

In view of the complexity of the task of rating level of object representation development and the degree of clinical judgment

required, the reliabilities attained support the clinical, global-style ratings involved in Krohn's scale. While exact agreement is not impressive, the two judges "came close" in most instances. A Pearson product-moment coefficient was calculated, indicating a correlation coefficient of .55, between the two judges' ratings on dreams and early memories, significant well beyond the .01 level of probability. Indicated on Table 14 is a chart of the two judges' ratings.

Table 14

Two Raters' Scores on the Krohn Object Representation Scale for Dreams (As Used on Dreams and Early Memories)

Rater 1's scale scores	Rater 2's scale scores							
	1	2	3	4	5	6	7	8
1								
2		4*	3		1			
3		4	22*	2	5	1		
4			13	32*	10	3	1	
5			10	5	23*	2		
6				7	2	8*	3	
7			1		2		1*	
8					1			

*Exact agreement.

Comparison of High Tolerance and Low Tolerance Groups' Scores on Early Memories and Dreams

The primary hypothesis of the study stated that high tolerance subjects should obtain higher object representation scores than low

tolerance subjects, given the notion that mature object representation development allows greater capacity to tolerate physical isolation. Thus it was expected that scores of dreams, early memories, and Object Relations Technique stories should have been higher in the high tolerance group than in the low tolerance group. No significant differences were found between the mean scores of the two groups on the ORT stories. However, dream and early memory scores do provide partial support for this hypothesis.

Object representation scores of the two groups on early memories showed significant differences. A mean score for the entire group was computed (4.56), and the experimenter counted the number of subjects in both groups whose mean scores on early memories were over this mean, and under this mean. A chi-square table (Table 15) and formula were used to find that the high tolerance group, as expected, produced early memories which were scored as having more developed object representations than were those of the low tolerance group. A chi-square of 4.53 was obtained, significant at greater than .05 level.

Mean scores on dreams for the two groups were not significantly different. A chi-square comparing the numbers of subjects scoring above and below the overall dream score was .60. The mean score for both dreams and early memories of the high tolerance group (4.65) was also not significantly different from the mean score of dreams and early memories of the low tolerance group (4.02). However, other

Table 15

A Comparison of Numbers of Subjects in High or Low Tolerance Groups Scoring Above and Below the Mean on Early Memories

	Tolerance group	
	Low	High
Number of subjects with mean scores over 4.56	2	5
Number of subjects with mean scores under 4.56	12	2

differences between the two groups emerged. Table 16 shows that while both groups had a majority of "4" and "5" scores, there were differences in the two groups' percentages of low and high scores. That is, more low tolerance subjects obtained scores of "2" or "3" than did high tolerance subjects, and fewer low tolerance subjects obtained high scores on Krohn's scale than did the high tolerance subjects. These findings are in the predicted directions.

Table 16

A Comparison of Percentage of Scores on Dreams and Early Memories in High and Low Tolerance Groups

Percentage of scores	Tolerance of aloneness	
	Low	High
"2" and "3"	32.2	17.6
"4" and "5"	62.6	50.9
"6" and "7"	5.2	29.4

A chi-square formula was used to compare the number of high tolerance subjects obtaining a score of 2 or 3, with the number of low tolerance subjects obtaining a score of 2 or 3 (see Table 17).

Table 17

Comparison of Numbers of Low Scorers on Dreams and Early Memories in High and Low Tolerance Groups

	Tolerance of aloneness	
	Low	High
Number of subjects who obtained a "2" or "3" score	13	3
Number of subjects not scoring a "2" or "3" score	1	4

The chi-square value obtained was 3.97, significant at the .05 level. A similar approach was used to compare the two groups in the number of subjects achieving a high score of 6 or 7 (see Table 18). In this comparison, a chi-square of 5.47 was completed, also indicating a probability of less than .05 of occurrence.

Although significant differences were not found in the central tendencies of the two groups, comparisons of the numbers of subjects achieving high and low scores were significantly different for the high tolerance and low tolerance groups.

Table 18

Comparison of Numbers of High Scorers on Dreams and Early Memories
in High and Low Tolerance Groups

	Tolerance of aloneness	
	Low	High
Number of subjects obtaining a "6" or "7"	5	7
Number of subjects not obtaining a "6" or "7"	9	0

CHAPTER 9

DISCUSSION

Interview Data

Several findings from the interview data seemed important. First, all 56 subjects could describe times in which physical isolation was valuable, as productive time in which concentration was possible; as an opportunity for special thinking, organizing, assessing, or planning; or as time connoting "freedom," "quiet," and "privacy." Even subjects who complained of frequent, very painful reactions to aloneness seemed to recognize that it was somehow good for them to be alone at times, in the same way that Larson and Csikszentmihalyi (1978) likened aloneness to a "bad-tasting medicine," (unpleasant, but necessary) in their study of adolescents' reactions to time spent alone. To the experimenter's surprise, being with others was described as the "bad-tasting medicine" by a sizeable number of subjects. This was perhaps due to self-selection factors which will be discussed later.

That aloneness was at times valuable was probably the only statement upon which all subjects agreed. Certainly, subjects' definitions and connotations of aloneness were varied. Frieda Fromm-Reichman (1959) had noted that several distinguishable experiences are lumped together as "loneliness": "aloneness, isolation, loneliness in cultural groups, self-imposed aloneness, compulsory solitude and real loneliness." All these categories of experience came up during the subjects'

discussions of aloneness, yet the subjects used the meanings interchangeably at times. There did not seem to be a formulation of the relationship between physical and mental aloneness that applied to all subjects. Some subjects (11%) used aloneness synonymously with loneliness. Some subjects reported that aloneness and loneliness were related, often in the sense that lonely feelings were more likely to occur during periods of physical isolation. Some subjects (18%) clearly distinguished loneliness from physical aloneness, and others (39%) discussed both physical and mental isolation without clarifying the relationship or distinction. However, when asked to describe times when they had been uncomfortable in physical aloneness, over 75% discussed loneliness. To the author, it seemed that loneliness (longing for contact) was a painful experience which could occur during times spent in physical isolation, but did not occur at every instance of physical isolation. Loneliness or "feeling alone" could also occur when subjects were with people. Not only did many subjects describe feeling "lonely in a crowd" of strangers, but several subjects described a feeling of aloneness which could occur during an interaction with someone they knew. That is, a few subjects seemed to become aware of the inadequacy of the relationship during conversation or sexual intercourse, and thus "felt alone." Loneliness was rarely caused by physical isolation, but could in some cases be intensified by aloneness.

Loneliness implies a sense of mental isolation or ego-unrelatedness. However, some subjects experienced painful affect when alone without losing the feeling of relatedness to others. One

way of understanding the distinction between loneliness and painful experiences in aloneness involves reference to Klein's work (1975). Klein discussed the paranoid and depressive positions both as a means of understanding early childhood development and adult personality development. In the paranoid position, there is less integration of affective object representations, and the individual's lack of ego development gives rise to problems in maintaining a steady sense of relatedness. This sense of relatedness is interrupted by the persecutory part-objects which people the internal world of a person at the paranoid position. At the depressive position, aloneness does not imply disruption of ego-relatedness. Instead, aloneness may allow the painful experience of loss and mourning. While this may be uncomfortable, it suggests a developmental achievement which makes possible a sense of mastery and forward motion.

It seems important to distinguish loneliness from aloneness. Even for those who equated loneliness and aloneness in their definitions, there were periods of aloneness which might be more aptly described as solitude. As has been discussed, all subjects described positive values of aloneness, in which, for example, they were able to concentrate productively or think in a special way. Thus, aloneness was not consistently experienced negatively by any of the 56 subjects. Furthermore, when time alone did result in discomfort, loneliness was only one of several types of discomfort.

The differences in amounts of time spent alone were striking, ranging from an estimated $4\frac{1}{2}$ hours per week to 108 hours per week.

These figures included waking hours only. If one assumes a person sleeps an average of 8 hours per night, this range would represent 4% to 96% of a person's waking hours spent in isolation, with the mean hours per week for all subjects representing 30% of their waking hours. Interestingly, subjects selected for the high tolerance group spent less time alone than did the low tolerance subjects, although this finding could be accounted for by the fact that more high tolerance subjects (6 of 7) were married and living with families than low tolerance subjects, a sizeable percentage of whom (43%) lived alone. Subjects most tolerant of aloneness were more apt to be successful in establishing lasting intimate relationships, judging by these figures. This research artifact makes good sense theoretically. Guntrip (1969) suggests that the capacity to be alone is a function of ego-relatedness, a capacity which allows the individual to tolerate isolation and to risk intimacy. Wexler and Steidl (1978) view the capacity to be alone as a prerequisite for a healthy marital relationship. When both individuals feel tolerant of physical isolation and of their own uniqueness, differences can be accepted and worked through. When individuals fear aloneness and seek fusion with a marital partner, serious problems are inevitable.

Subjects described various types of discomfort in aloneness: loneliness, longing for contact or someone to talk to, differentness, self-pity, restlessness, anxiety, panic, vulnerability to physical threat, boredom, depression or magnification of depression, fears of going crazy, fears of suicide, emptiness, desires for physical contact

and identity disturbances. There are similarities in these sorts of discomfort and the four clusters of feelings in loneliness found by Rubenstein and Shaver (1982): desperation, depression, impatient boredom, and self-deprecation.

There was a spiraling of depression reported or implied by 68% of the subjects; in addition, 43% of the subjects reported or implied a spiraling effect of aloneness on anxiety. Subjects stated that this was due to their tendency to focus on negative affect when alone; they were unable to "change the subject" and became increasingly depressed and at times inactive, which was likely to make things worse. For some, the fact of aloneness increased depression because the subjects felt rejected or "handicapped" and unwanted. Jeffrey Young described "lonely depression" in an interview with Jeff Meer (1985). Young described a "spiraling pattern" in which loneliness (separation anxiety) leads to depression and low self-esteem. The depression makes the formation of fulfilling relationships more difficult. The longer the person suffers "lonely depression," the more likely he or she is to avoid close relationships, which increases the isolation and decreases the possibility of obtaining positive social reinforcement. Also, Young (1982) has reported that the absence of close attachments allows the maintenance of cognitive errors, such as unrealistic expectations of friends and partners, or beliefs that one is unattractive or unloveable. Young argues for a cognitive approach in treating the chronically lonely, to interrupt the spiraling of depression and isolation. It is interesting that the chronic spiraling pattern Young describes seems to occur on a more minute level for many people.

Subjects responded to their discomfort with a variety of behavioral responses. Some subjects did nothing but experience their painful feelings; some slept to avoid the experience. Some reported making social contacts with friends, family, or neighbors. For some, unselective contact--being among people--provided relief. Various sources of external stimulation (radio, television, stereo, movies, driving, video games) were commonly used to distract or calm subjects, as well as various activities (studies, housecleaning, work tasks, creative pursuits, reading, exercise). Use of drugs, alcohol, and food were frequently reported responses, varying from occasional experimental use to severe abuse. Other responses reported include contact with pets, prayer/mediation, measures to increase physical safety, planning, writing, autoerotic stimulation (bathing, masturbating), physical contact with a child or sexual partner, breaking things, self-mutilation, fantasy, and reviewing memories of loved ones. This listing gives a feel for the constructive and destructive options for coping with painful feelings accompanying physical isolation. These behavioral responses are similar to the clusters reported by Rubenstein and Shaver (1982): sad passivity (crying, sleeping, thinking, doing nothing, eating, taking tranquilizers, watching television, and drinking or getting "stoned"), active solitude (studying or working, writing, listening to music, exercising, walking, working on a hobby, going to a movie, reading, playing music), spending money (spending money, going shopping), and social contact (calling a friend, visiting someone).

As became clear both in discussions of activity as a coping tool and in discussions of lack of activity as a stress to tolerance of aloneness, discomfort in aloneness became more likely for a majority of subjects under conditions offering the least structure. Seventy-three percent of subjects reported use of activity to lessen distress; 61% of subjects reported use of radio or television in response to distress; 41% of subjects reported specifically that discomfort was increased when they were "not busy." These responses provide some support for hypothesis number one: that unstructured time alone is apt to provoke greater discomfort than structured time alone. The fact that unchosen aloneness was reported as stressful by 64% of the sample suggests support for the hypothesis that, as aloneness connotes being left or abandoned, it is apt to be more uncomfortable. It is interesting that, by allowing the welling up and recognition of personal feelings and awarenesses, unstructured aloneness was considered a valuable experience (by 48% of the subjects) as well as a source of discomfort. Subjects sought alone time because it provided an opportunity to identify feelings, and perform special thinking or assessing. However, subjects became more aware of all feelings when alone, and negative feelings tended to be more intensely experienced. Sometimes an emotional reaction could become overwhelming in aloneness, as in the woman whose grief states led to hallucinatory experiences and as in the young male who could not tolerate awareness of his rage "at having been born." This man's rage seemed to disrupt his ego-relatedness and his sense of himself and others, thus making aloneness intolerable. Adler and Buie (1979) have reported this pattern

in borderline patients, and Wagner and Fine (1978) have similarly described the negative effect of a child's anger on the maintenance of good internal images of the mothering one.

Two of the subjects were quite articulate in their description of the emptiness and identity diffusion, which meshes with clinical descriptions in the literature. One woman described her experience of feeling "like I don't exist," "like there's no me at all," at times when she was alone--a literal "void" which she could fill only by interpersonal contact or by self-abuse, both of which seemed to reassure her of her existence. Another young woman described her "invisibility" when she was with others with whom she felt no sense of relatedness. The lack of a stable self-image in these two women was clear-cut, and brought to mind Kumin's (1978) hypothesis of an "empty ego core" and failure to retain differentiated object representations in certain schizoid and narcissistic individuals.

High and Low Tolerance Groups

While tolerance of aloneness could be judged reliably by two raters, the project of rating tolerance of aloneness was by no means simple or clear-cut. Therapists' ratings did not consistently agree with those of the two raters of interviews. Subjects, particularly schizoid subjects, presented contradictions in their experience and in their behavior. Subjects who seemed normally very comfortable in aloneness (who might structure their lives to provide much alone time) reported extreme discomfort under certain circumstances; one subject

glorified her "highest highs" in alone time but also reported experiencing her "lowest lows."

The method used in obtaining subjects (distribution of a notice to eligible outpatients informing them of the nature of the study) seemed to have recruited many subjects for whom aloneness was a central psychological issue--people who wanted to discuss aloneness and learn from the experience. It seemed to attract a proportionately large number of subjects with schizoid personalities. Although the interviews were not designed to elicit diagnostic information, 12 subjects (21%) appeared to the examiner to have extreme difficulties initiating and/or maintaining relationships, especially close relationships, due to their sense of vulnerability to abandonment or rejection, due to a desire to maintain control, or due to passivity and limited social skills. In these 12 subjects, there seemed to be significant withdrawal from relationships, often recognized and lamented. Seven of these people specifically noted that being with people was more uncomfortable than being alone: "less relaxed," more tiring, "a chore," "more pressured," causing feelings of "invasion," "fragmentation," and/or confusion. An additional 19 subjects were judged by the experimenter to have moderate schizoid qualities, although less severe than the 12 described. Seven of the twelve very schizoid and four of these somewhat schizoid subjects noted a significant degree of isolation growing up: no peers in the neighborhood with whom to play due to rural isolation, lack of or separation from siblings or extended family, and/or getting "picked on" in school. Four of these subjects

mentioned the importance of fantasy, imaginary relationships, in the absence of childhood friends. It is very interesting that several of these quite isolated subjects, many of whom had the highest average number of hours spent alone per week of the subjects studied, were not consistently tolerant of aloneness. Only one of the twelve most schizoid subjects was chosen for the high tolerance of aloneness group; he alone of this group of 12 seemed consistently comfortable in his physical isolation. Most of these subjects expressed occasional extreme discomfort with aloneness, which perhaps because of their fear of relationships, they handled in self-destructive, or at least unselective ways which spoke to a sense of urgency and desperation. These descriptions of periods of extreme discomfort often accompanied by destructive coping skills in the context of an apparent preference for aloneness led to disagreements between judges and therapists in tolerance of aloneness ratings.

While the raters developed a strategy of rating the contradicting messages, therapists did not have the benefit of the discussion or training. Therapists seemed to label as "average" more subjects than the raters, perhaps as a means of communicating that their clients had aspects of "high tolerance" and aspects of "low tolerance" of aloneness. In addition, when subjects expressed a typical preference for aloneness and a tendency to spend a great deal of time alone, some therapists seemed to ignore indications that they were occasionally extremely self-destructive and highly uncomfortable in aloneness.

There may be several reasons for the therapists' general tendency to rate tolerance of aloneness higher than the raters. To begin with,

therapists had different information on which to base a judgment; they did not have access to the responses to the interviewer's pointed questions designed to uncover the nature of discomfort in aloneness. Secondly, as clinicians, they may have viewed their clients on a different continuum. The therapists were supplied with definitions of high, average, and low tolerance ratings in reference to an outpatient "standard" (Appendix E). However, while the raters could compare the subjects' interview data with that of the other subjects, the therapists may have compared their subjects to a continuum of more severe psychopathology. In addition, the therapists' ratings may have been an expression of their investment in their patients' success in therapy. This investment may have prevented identification of pathological responses to aloneness.

Beyond the possible reasons for the therapists' tendency to rate tolerance of aloneness higher than did the raters, disagreements between the ratings seemed to stem from the difficulty in so many cases to view tolerance of aloneness as a simple trait. The interviews gave grounds to question the experimenter's basic assumption that one's tolerance of aloneness can be solely considered a relatively consistent personal quality. One subject after another told the experimenter of circumstances which disrupted his or her tolerance of aloneness; stresses such as divorce, problems in a relationship, temporary separations, schedule conflicts, cultural and other differences, moves, lack of access to friends or relatives, the experience of rejection, physical assault, moods, and a variety of other stresses.

It seems probably that tolerance of aloneness is determined by both circumstances and characterological components, as Nevils (1978), Cutrona (1982), and Jones (1982) found true of loneliness. Certainly, the study provides phenomenological evidence for the existence of situational and chronic discomfort in aloneness, as Young (1982), Cutrona (1982), and De Jong-Gierveld and Raadschelders (1982) found of loneliness. The experimenter had assumed that intolerance of aloneness was not equivalent to loneliness in designing the research, but found a great deal of overlap in the two experiences. Like loneliness, tolerance of aloneness appears to be influenced by a person's actions, as well as his or her situations. Subjects noted attempts to change their tolerance of aloneness (either to be more tolerant or less tolerant of physical aloneness) in therapy and described experimentation to evolve better ways of dealing with aloneness. A few subjects described learning to live alone as an active process.

Furthermore, tolerance of aloneness seemed to rest on a multitude of psychological qualities. The author speculates that in attempting to rate tolerance of aloneness, the judges and therapists were assessing several different qualities (in addition to stress and/or situational factors). One of the separate qualities suggested by the research interviews was the degree of stimulation-seeking present in the individual. In a massive and impressive review of the literature on sensation-seeking, Zuckerman (1984) reported that work with scales measuring sensation seeking had isolated four factors: thrill and adventure seeking, experience seeking, disinhibition, and boredom

susceptibility. He defined thrill and adventure seeking as "sensation-seeking through risky or exciting behavior," and experience-seeking as obtained "through the mind or senses and through a nonconforming life style." Disinhibition involved seeking social stimulation and reduction of inhibitions through social drinking. Boredom susceptibility was defined as the occurrence of restlessness as a reaction to monotony. The factors, especially boredom susceptibility, seem relevant to understanding tolerance of aloneness in at least 15 subjects who mentioned boredom or restlessness as a reaction to aloneness. Zuckerman reported many studies validating the scales with measurable behavioral correlates, and also reviewed the literature which suggests physiological correlates of sensation seeking, notably measured levels of gonadal hormones (testosterone) and levels of monoamine oxidase in blood platelets, as well as other neuroregulators and neurotransmitters. From studies of animals and humans, Zuckerman drew the tentative conclusion that for each individual, there is an optimal level of arousal/stimulation which is based on activity in the catecholamine systems. He hypothesized that at the optimal levels of catecholamine system activity, mood is positive and social activity is adaptive, but at either very low or very high levels, mood is dysphoric; activity is restricted; and sociability is characterized either as withdrawn or as aggressive. Zuckerman offered some evidence that the sensation-seeking trait is based on inherited constitutional differences, but could not rule out environmental influence.

Thus, Zuckerman (1984) suggests that for high sensation-seekers, aloneness may be uncomfortable at least in part because of the state of activity in the catecholamine systems, a factor he views as constitutional. The complex constitutional factor may be an additional way of accounting for intolerance of aloneness besides the development of internal object relations; its presence may partially explain the incomplete support for the primary hypothesis of the research.

Other separate qualities suggested by the research interviews which affected tolerance of aloneness included (1) interest and skill in solitary activities (reading, writing, etcetera), (2) reactivity to control issues, (3) general ability to modulate affect and control impulses, (4) a person's sensitivity to abandonment (probably based on object constancy as well as the development of personal identity), and (5) general self-esteem, especially confidence in social skills. These qualities may be reflections of Guntrip's ego-relatedness and development of internal object representations. Because physical aloneness so often seemed to intensify the subjects' existing feelings, subjects who felt able to modulate and handle their emotions and who felt they had access to supportive resources (people with whom they could discuss feelings), were less likely to report panicky feelings of discomfort. The general factor of ego-relatedness and good mental health which Winnicott and Guntrip associated with the capacity to be alone seems to be operating in many senses, although it is not clear whether the capacity to be alone allows general mental health or vice versa. The

persons who were chosen as the high tolerance subjects seemed less subject to intense episodes of depression or anxiety, or at any rate, less fearful of these experiences than the low tolerance subjects. High tolerance subjects described relatively productive, healthy styles of coping with distress in general. They reported many activities they could enjoy alone. Most had a sense of connectedness with others such that making social contact was not a frightening step, but a natural response. While control issues seemed prominent for a few of the high tolerance subjects, they seemed generally comfortable with the reality of not being in total control of their lives, of depending upon others at times. For some low tolerance subjects, this was not true. Finally, there was some evidence for one of the basic hypotheses of the study: development of tolerance of aloneness is related to the degree to which a person develops realistic, stable, available internal representations.

In an effort to confirm the theoretical work of Winnicott (1958), to add validation to the work of Mahler, Pine and Bergman (1975) and McDevitt (1975) on early development of object representations and object constancy, and to support the theoretical conclusions based on clinical work with patients suffering borderline and narcissistic disorders (Adler & Buie, 1979; Kernberg, 1975), a major purpose of the study was to test a basic idea: relative abilities to tolerate physical aloneness are based on the degree to which a person has internalized stable, whole object representations of the self and others. If this hypothesis were true, several experimental predictions could be made:

1. Members of the high tolerance group should have scored higher than the low tolerance group on their mean scores on the Krohn Object Representation Scale for Dreams on both dreams and early memories.

2. High tolerance subjects should have achieved higher scores compared with low tolerance subjects on the author's scales testing internal object representation development on the stories elicited by the Object Relations Technique.

Partial support was derived for the first hypothesis. Significantly more high tolerance subjects than low tolerance subjects attained mean scores on their early memories which were above the overall mean score. The difference in group performance was significant at the .05 level of probability. The fact that scores on early memories were higher indicates that high tolerance subjects tended to have richer, more integrated and realistic memories, less disrupted by aggressive impulses, for example. This would lend support to the notion of Adler and Buie (1975) that the development of evocative memory accounts for tolerance of aloneness in children and in adults. That is, the capacity to call up an image of a significant other is never mastered by some individuals, who, as a result, suffer from difficulties coping with alone time.

Data did not provide complete support for the first hypothesis, however. Means of dream scores tended to be higher for high tolerance subjects compared with low tolerance subjects also, but not at

statistically significant levels. However, there was a statistically significant trend in which high tolerance subjects were more likely to score at the high end of Krohn's scale on both dreams and early memories and less likely to score at the low end of the scale than were low tolerance subjects. This trend is in the direction predicted by Winnicott and Guntrip's theory, and, given the small sample size, reflects meaningful, although perhaps not dramatic, differences in the object representation development of the high tolerance and low tolerance groups.

The author's scales designed for use on the Object Relations Technique stories did not provide support for Hypothesis 2. No significant differences were found between groups on any of the scales. The author's scales were designed to be simply and reliably scored on the basis of several dimensions of object representation development. The design proved successful in generating reliability, but unsuccessful in providing for meaningful comparisons between groups. Three and four point scales were simply too collapsed and crude to reflect differences; scales of greater breadth are needed. The author speculates that the lack of significant differences between the two groups on the six scales may reflect first, overly simplified and collapsed scales, and second, limitations on the usefulness of the ORT for such scoring systems. As discussed earlier, ORT responses often seemed too stimulus-bound to be effective as projective material for analysis by Krohn's scale, and responses often seemed to reflect the subject's perceptions of experimenter demand. While the ORT undoubtedly

generates a rich source of content analyses in many patients, it does not seem to be an ideal instrument for measuring object representation development.

Implications for Future Research

Scoring Internal Object Representations

Examination of the raters' errors sheds light on some difficulties in Krohn's scale. A review of Table 14, p. 143, shows the breakdown of the two raters' agreements and disagreements. Distinctions between neighboring scale score points were understandably difficult at times; a trend developed in which Rater 1 tended to rate as "4" what Rater 2 rated as "3". What is surprising are the 15 errors in which one judge rated a "5" and the other scored a "3" and the 10 errors in which one judge rated a "6" and one rated a "4". In the discussions following ratings, it became clear that there were some facets of Krohn's scale which could be improved.

At the lower end, Krohn's scale (1974) begins with vacant, desolate, very bizarre images with no real portrayals of others ("1"). Scale score "2" portrays insubstantial, brutal, animalistic others (example: witch, half human/half animal). Scale "3" scores on dreams and memories portray insubstantial, unstable persons who have no enduring characteristics; nonsensical dreams are common in which the subject is unsure of who did what to whom. Krohn described scale score "4" as depicting the presence or felt absence of need gratification, in which the minimal interactions take place at a feeling level.

Note that the valence of a "4" could be either very positive or very negative. A score of "5" refers to stereotyped, interchangeable characters who are not massively distorted (examples: passersby, cowboy-types). There may be very little or nonsensical interaction. Here it seemed that there could be less interaction than in a "4" need fulfillment fantasy. Judges were instructed to rate as a "6" dreams or memories in which subjects portrayed specific people, not merely "passersby," but did not pay much attention to their interiority. Krohn defined their interactions as parallel, or perhaps avoiding involvement. Scores "7" and "8" referred to more unique characters with more understanding of thoughts, feelings, and conflicts.

Krohn's complete score descriptions are included in Appendix A, but from these brief summaries, some of the scoring problems can be illustrated. In some ways, a score of "3" was closer to a score of "5", in the degree of interaction portrayed and in the "shadowyness" of the figures. Dreams and memories scored as "4" might portray rather positive interactions of perhaps rather distinct characters which focused entirely on eating, sexual gratification, or other sensory experiences. A "4" score might be closer to a "6" than to a "5" in terms of its degree of definition and specificity of characters and again, the degree of interaction. Scores of "4" seemed most appropriate for dreams and memories which seemed very, very different from one another. The memory of yelling and screaming for mother, who never came, was scored a "4", as was a lengthy dream with multiple realistic characters focusing on sexual gratification. The judges

and the experimenter never successfully resolved the problems in understanding the scale as continuous, which Krohn (1974) intended, although they seemed to use it in accordance with his approach, judging by Krohn's agreements with judges on a few sample scoring problems (personal communication with Krohn, April 20, 1985; May 2, 1985; June 14, 1985).

When coming to a consensus agreement in a debate between a "5" and a "3", the judges decided on a "4" in only 1 out of 15 cases of disagreement. The rest were given a final score of either a "5" or a "3". In a "6-4" disagreement, judges chose the compromise score of "5" in only one-fifth of the cases, the rest being resolved with either a score of "4" or "6". This pattern suggests evidence for a flaw in the construction of a continuous scale and a need for reworking a scale to use in measuring developmental levels of internal object representations.

One solution to the difficulties discussed would be to score several dimensions separately. While the intuitive judgements obtained from Krohn's scale appeared meaningful to the author, it seemed that it "lumped together" several aspects which were frequently not in accord in an individual's projective productions. For example, it might be useful to use scales of similar breadth to measure distinct dimensions, such as description of humans, affective valence, nature of interaction, and possibly, degree of insight into self or others. Charles Jones, in his dissertation research now in progress (personal communication, May 28, 1985) is exploring the use of a multidimensional

object representations scale in an effort to solve these problems and to integrate the concepts behind several scales. To conclude, future researchers of correlates of object representation development will probably want to retain the technique of use of clinical, intuitive judgements, proven effective and valid by Krohn and Mayman, while improving the continuity of the scale, perhaps by looking at several dimensions separately. To be useful, improved scales should retain the breadth of a 7 or 8 point spread. As noted, the most projective, least stimulus-bound data, such as dreams or early memories, appeared to be the most successful in eliciting meaningfully scorable responses. Methods used to obtain projective data which provide a great deal of stimuli (even ambiguous stimuli) and which somehow allow subjects to construe assumptions about the content the experimenter is "looking for" are not recommended for use with Krohn's scale or similar scales, on the basis of this study. Gathering a series of projective productions also seems important in gaining a range of scores most descriptive of object representation development.

Need for Phenomenological Data

This study underscored the value of exploratory interview data. The 56 interview collected painted an interesting, complex picture of the nature of adult therapy patients' experiences of aloneness, the nature of their discomfort in aloneness and their responses to it, and some of the reasons for their discomfort, in a lengthy interview. The subjects seemed quite willing to reveal and explore in depth even

painful experiences which might be considered signs of weakness or undesirability by American culture. Only two or three of the subjects were judged by the experimenter to be underreporting the impact of "negative" feelings or experiences in a defensive reaction. In these few cases, subjects contradicted themselves and/or reported relatively unselective/destructive reactions to aloneness without reporting much discomfort. On the whole, the self-reports were believed to be honest, useful assessments, pointing to both the astounding variation in experience and to some common responses to aloneness.

On the basis of the experimenter's experience with the informative, valuable self-reports, use of relatively lengthy, relatively open-ended clinical interviews are recommended to collect phenomenological data in future research endeavors. A phenomenological study of the experiences of loneliness and discomfort in aloneness of a "normal" population of relatively healthy individuals (not in current psychological treatment) would be of tremendous value in expanding this frontier of research. While research on loneliness in normals has been conducted in the past (often via written forced-choice scales), the use of open-ended interview material on loneliness could provide a great deal of new information, with greater applicability than the current study and usefulness in comparing the experiences of a clinical population with those of "normals." In future studies, loneliness researchers should not assume that loneliness and discomfort in physical aloneness are equivalent. This study definitely indicates that while the two concepts overlap, they may be distinctly different experiences

for many individuals. Discomfort in aloneness may involve fear or boredom, for example, rather than loneliness, and loneliness may not be a reaction to physical aloneness.

Implications for Clinical Work

The author saw three outstanding implications for clinical work resulting from the study. First, questions about tolerance of aloneness would be a valuable addition to an intake interview with a prospective outpatient client. There are several reasons for this. A patient's response to queries about alone experiences would give a therapist a clue to a patient's general level of distress or level of general mental health, as Guntrip (1969) indicates. Also, such interview material offers an assessment of the subject's usual means of coping with distress. For some of the subjects interviewed, highly destructive behavioral responses seemed to occur as a reaction to aloneness; other subjects reported a pattern of doing nothing when faced with discomfort. Finally, asking clients about tolerance of aloneness is likely to quickly bring into focus stressful situational factors, such as cultural differences, experience of assault, relationship problems and dissolutions of important relationships. The following questions provide examples of some useful queries: "What is it like for you to be alone? Tell me about times when you are uncomfortable because you are alone? What do you usually do when you become uncomfortable?"

A second result with implications for clinical workers is the finding that highly schizoid patients who frequently avoid interaction do at times experience painful reactions to aloneness. As Kumin (1978) describes, schizoid patients complain of inner emptiness at the same time that they avoid relationships. They are not necessarily consistently comfortable with aloneness, and may experience intensely painful longing for contact. In other words, patients who report that relationships and interactions are uncomfortable and painful may nevertheless be discomforted at times by the aloneness they appear to prefer. This understanding gives the therapist some leverage in working with avoidant patients. Resistance should not be interpreted as a lack of motivation to change. The therapeutic relationship may be frightening, yet of enormous importance to the patient in providing a bit of the needed contact.

A third area involves the study's support for Winnicott's notion that the capacity to be alone is a function of a healthy sense of relatedness and the development of solid, integrated internal representations. The trends and positive confirmations found in this small sample lend some support to the conclusion that certain therapeutic tasks are priorities for some patients who report extreme discomfort in aloneness. This is probably especially true for those patients who do not seem to be reacting to life stresses experienced in adulthood or who are clearly overreacting to life stresses. For these patients who seem chronically uncomfortable in aloneness (at least at times), intolerance of aloneness reflects a lack of stable or integrated internal

objects, including self-objects. In order to increase self-esteem, a sense of identity, and a relatively consistent sense of relatedness, the therapeutic task is a reconstructive one likely to involve a long-term process. In this process, the therapist provides a steady availability and "optimal distance" from the patient, in a similar role to that of the "good-enough mother" for her toddler. With the therapist's reliable availability, acceptance of reparation, and predictable adherence to therapeutic boundaries (which may be perceived as preventing intrusion or engulfment), the patient may first develop an internal whole image of the therapist, which will better enable him or her to tolerate aloneness comfortably.

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APPENDICES

APPENDIX A

OBJECT-REPRESENTATION SCALE FOR DREAMS*
(Alan Krohn, Ph.D.)

GENERAL INSTRUCTIONS:

First, read over the scale.

This scale attempts to register the sense the subject has of objects in his world--how primitive, shadowy, malevolent, anonymous, stereotyped, or one-dimensional they are on the one hand, or how full, defined, feeling and in general human and complete they are on the other. Your task is to infer this overall quality of the patient's inner object world from his dreams. Let the dream wash over you, let your clinical "feel" tell you how human, how real, how whole, and how mature are the people as the dreamer experiences them. The scale rests on your global sense of the dream and therefore I would like to encourage you to use your intuition and empathy in any way you can.

Each point on the scale is defined in three ways: a global description of the nature of the object world, some typical characteristics to look for in the dream, and a sample dream. I would like you to rely most heavily on the global description of the scale points and the sample dream that illustrates that description. The typical characteristics are features of the dreams that tended to correlate with each of the global descriptions. The criteria should be used as aids to your intuition and are not intended to be used instead of your overall sense of the dream. Indeed, if you have a clear sense of the dream's location on the scale and the dream does not contain any of the characteristics, simply ignore the typical characteristics. These characteristics are intended to be signposts to supplement your intuition, not constrict it.

SPECIAL SCORING NOTES:

1. Many dreams contain several characters. If a dream contains even one character that clearly meets the criteria in categories 2, 3, or 4, give particular weight to that.

2. If the dream seems to have two almost equally important portions with very different kinds of characters in each, give a score for what seems to be the more salient quality of the dream and then a supplementary code for the quality of the object in the secondary portion of the dream.

*As well, the scale has been applied to the Early Memories Test and Rorschach Test productions and by therapists to their long-term psychotherapy patients (Krohn, A. & Mayman, M., Bulletin of the Menninger Clinic, 1974).

3. Dreams that contain no people (other than dreamer) in them present some special difficulties. Handle them as follows: first, indicate that there are no objects explicitly represented in them by the code NO, then try to code on the object representation scale by asking yourself if some inanimate object or animal in the dream seems to have human qualities. If something seems to represent, with some subtlety, a person, then score the dream in category 6. The final code would then be NO 6. These nonhuman elements which stand for objects may be buildings, the overall setting, animals or even place names. If nothing in the dream seems to represent an object, try to capture the overall object quality of the subject from the global descriptions in the scale and assign a code from categories 1-5.

SCALE POINTS:

1. The subject's world seems to be completely lifeless, vacant, alien, strange; it is a world essentially without people; he experiences the world as very stark and static or very fluid and formless; in short, the world for him is an unpredictable, desolate, often strange and bizarre place that he only rarely understands.

For Example:

1. The dream is virtually devoid of people or human-like figures; if people are present as dream figures at all, they are unnamed, extremely vague, and incidental to the action of the dream.

2. The dream setting is either very fluid or almost frozen (or both).

3. As the dream is read it may give you a distinctly "other-worldly," unsettling feeling.

Sample Dreams:

I dreamt that I was walking into a forest, the birds were singing and the sun was out, then all of a sudden the trees, rocks and bushes began to melt, all run together with the ground, just everything all combining. Then the animals came running out of different places and coming after me and they too sort of started to dissolve into each other, to melt together.

I'm walking underwater and kind of half swimming and half walking through the water, it's all around me, this fluid maybe a little thicker than water, and there are large, whale-like things, but smaller than whales--someone I told the dream to said they seemed like they were like sperm, and as I walked through the water they part, just ahead of me. There may be more but that's all I remember of the dream.

2. The subject's internal world includes people, but not really alive, human, benevolent. People are insubstantial figures, prone to seem malevolent, brutal, murderous, extremely cold, mechanical, less

than human. The subject's sense of people seems bizarre and distorted. More specifically, it seems that under the pressure of morbid, sadistic, murderous impulses and fantasies, people become transformed into malevolent, animalistic figures. There is no internal experience of real interaction among people, for others are experienced as little more than the subject's own primitive impulses incarnate.

For Example:

1. A figure in the dream is half animal, half human; animal turns into a person, or vice versa.
2. A dream character is dead, dying, about to die, or killed--each in either a bizarre, brutal, very explicit or morbid fashion.
3. A dream character or the dreamer is doing something which is bizarre, morbid or terribly brutal.
4. A person appears in the dream who is labeled a witch, devil, robot (a malevolent, cold, though not necessarily bizarre, humanoid figure).

Sample Dreams:

I was living in a big old house; with other people in it. B. from the library was there. Others came over, they were sloppy and asked if they could use the living room to study in. I didn't want them to but for some reason I consented. They were ugly people. One girl looked like a man. She had a mustache and short, blond hair. They just took over the place, assuming they could stay. I said no. N. came; I was afraid she would say they could stay. They were just about leaving. Then G. came--beautiful G. She was a little girl. I knew she was dead already. Her body was simply warmed--being taken to her grave. She kissed me goodbye and trotted out in a little gray coat. She didn't know it but she was going to her grave. I remember thinking whether they would make her lie down in the casket and just close it or would somehow put her to sleep first.

I was with a group of people in the front yard of a big white house. We were just sitting around talking about how nice the weather was. I don't remember how, but all of the people began to look like animals. My friends were some of the animals, I could tell by their voices who they were, there was a gorilla, (my boyfriend), a zebra (a good girlfriend of mine) and various other people that I know. I didn't know all of them though, but they were all animals. I remember thinking that they were going to kill me, but they hadn't made any attempts or anything. I ran away into a child's playground and was playing on things there and I was coming down a slide and when I reached the bottom there were two animals whom I thought were waiting to "get" me, so I ran and I saw a construction site on the side of the road so I jumped into this big hole which had a big pile of dirt right next to it. I remember right after I jumped into the hole I thought that if I stayed in the hole and "if they" found me they would bury me alive. I climbed out of the hole and ran again; this

time I ran back to the house where it all began. I rushed upstairs into a bedroom and sat frozen on the bed. I remember hearing some voices coming from downstairs so I opened the door when I heard "them" coming up the stairs. I ran to the stairway leading to the part of the house where they were at and the animals were people again. They had long knives in each hand and my boyfriend was leading the group. I ran back to the door and ran outside. It was raining, the sun was shining brilliantly and these little animals were climbing all over me, clawing at my face and scratching my arms and I tried to get them off me, but every time I knocked one off there was another to take its place.

3. People are experienced as insubstantial, fluid, more or less interchangeable, but are not experienced as malevolent as in #2. Though people do not seem bizarre or aggress against one another as in previous categories, the subject experiences others in a vague, fluid and undefined fashion. The subject cannot really articulate what someone means to him, because he has such an undifferentiated concept of what other people want, feel or do. Such subjects may be unsure who did what to whom, for his internal representations of other people are so unstable, diminished and distorted and because his sense of his own boundaries and the boundaries of other people is so poor. This category is very similar to #2 but different in important ways too: the subject experiences others as confusing, fluid and without any enduring characteristics he can bank on, but not pervasively malevolent, weird, mysterious or strange. Listening to this kind of subject describe an interaction, one would continually hear rather flagrant contradictions in the way other people are depicted. This arises out of the subject's limited capacity to form a meaningful "gestalt" of another person, leaving him with a set of moment-to-moment impressions that fail to capture what is enduring and salient about other people.

For Example:

1. A person changes into another person, comes to resemble another, is a combination of two people.
2. Some aspect of a dream character changes in an unreal way in the dream.
3. A dream character is a combination of two innocuous, stereotyped, fictional or distant public figures--elves, gremlins, actors.
4. An animal metamorphoses in some way.
5. A person is dead or killed, but in nonbizarre ways, in inexplicit ways--usually not in front of the dreamer, usually not including gory details.

Sample Dream:

I dreamed I was coming here to see my therapist and I walked in and he was sitting there as he usually does, but he was different because he was just like he usually is up to his shoulders and neck,

but from his neck up he looked like a dwarf, as if his head were very small.

4. The subject's experience of people is to a very great extent fashioned around the need they can quite directly gratify in the subject and/or around the needs the subject can directly gratify in the other. In this sense people are experienced in a very incomplete way: aspects of the other that do not bear directly on the exchange of gratification are only partially perceived and understood. Put another way, the tremendous importance of other people as gratifiers leads the subject to be only vaguely aware of qualities of the other that exist apart from its need-gratifying function.

For Example:

1. Very minimal interaction of a dream character with the dreamer, and what interaction there is involves the dream character satisfying emotional (instinctual) needs of the dreamer and/or the converse situation.

2. People interact predominantly on a feeling level with the dreamer, without much explicit interaction.

3. Dreamer is involved in self-directed activity exclusively--preening, admiring own body, practicing something--with others watching or absent.

Sample Dreams:

My girlfriend B. and I are at the carnival at night with another couple. We are walking down this dark alley and I now notice how really sexy this other girl is. As if by my silent command she walks over to me and embraces me. She is rubbing her beautiful legs up and down on mine as we stood there in the dark. I looked up to see what Becky would do and this other guy came over to her and started to seduce her Bob, Ted, Carol and Alice-style. I got very mad and started punching this other girl; the dream ended there.

The second dream was about a young girl in the hospital. The hospital beds were very comfortable and the food was good. The girl did not seem to be suffering much. The girl's mother was very kind and very concerned while the girl was in the hospital. When she left the hospital the warm feelings faded. The mother and daughter went to the pier and there was a lot of noise and confusion. The mother was being "tempted" by a man offering her perfume. The girl kept thinking how happy she was at the hospital with the clean covers and the pretty, colorful bedspreads.

5. The subject's world is experienced as populated with other people who are neither fluid nor massively distorted by poorly integrated affects, but who do not have real identity. There is a sense that people are more or less interchangeable for the subject. People either seem very shadowy and their motives are unclear to the

dreamer, or else they are experienced in stereotyped ways. People do not really make sense to the subject: for example, he hears them but is often unsure of how they are meaning what they are saying; he is either deaf to what is implicit in what they are saying or reads a great deal of implication and hidden messages into what they are saying. There is no real depth, specificity or uniqueness to the people in the subject's world. His world seems to be populated with "passersby," so to speak, who either differ little from one another or who fall into one of several rigid, superficial categories. These subjects may try to use highly intellectualized, at times "symbolic" notions of people.

For Example:

1. If people known to the dreamer appear in the dream, they are involved in no thought, feeling or intention; they may be doing things, but with no sense of goal or intent; there is no explicit interaction with the dreamer; people may even talk to the dreamer or minimally interact with him, but the interaction or conversation is really only part of some action in the dream.

2. All the people in the dream are anonymous or nearly so.

3. Much said and done by others in the dream seems unclear, vague, nonsensical, "implicit" to the dreamer or highly symbolic.

4. People in the dream are described as innocuous stereotypes ("lazy men," "lumberjack types").

Sample Dreams:

I was walking or driving down a street that seemed like C. road (near where I grew up). The houses were very ordinary. I especially noticed many men standing around (I was alone). The men all seemed to be wearing blue denim pants and shirts and cowboy hats. They all seemed like truck driver types. Soon I was with someone (I think), probably my friend E. (female), and we were driving away from them, but we still saw some along the way. We drove on a winding country road--sunset. It was hilly and green. Although the guys didn't bother us we were fearful (or I was) of them.

A male person (I think it's me) is captive by a group of other males, all wearing white coats. There is a discussion of when to ask for ransom. Someone said at night, because newspapers work faster at night. Then they decide to execute. Someone says it would be too obvious if the whole group did, because everyone could tell who did it by the white coats, so one person is chosen to do it on his own. Someone says to do it in the day because "at the newspapers, the work lights shone brightest at midnight." Then someone else said, "But it's only 4:30 in Algeria."

* * * * *

In the categories that follow the subject has a much richer experience of people, is more tuned into their needs, motives and individual differences. People become more defined and therefore more unique

and individual for the subject. Fantasies, fears, needs, guilts and conflicts among them all have an impact on the subject's feelings towards others, but others always maintain a basic humanness and wholeness within the subject. Categories 6-8 try to tap differences in the amount and quality of internal commerce with objects. Beyond feeling whole and human, how much range does there seem to be in the subject's inner repertoire of objects? How much and how readily does the subject consider the feelings and implicit aims of those around him? In general, how subtle and differentiated is his experience of others?

6. The subject has a firm hold on objects and generally conforms to the description above. However he does not readily, whether for defensive or characterological reasons, try to understand the inner experience of other people--their feelings, thoughts, wishes, etc. Due to neurotic preconceptions and preoccupations, people do not feel to the subject to be able to interact in easy, mutual fashion. Neurotic conflicts lead the subject to want to be with people, but in a parallel activity or at a safe distance from others. This type of subject is dealing with his conflicts by steering clear of others, avoiding the more intense involvements particularly, that bring his conflicts to the fore and cause him discomfort. This subject might be little aware of any intense conflicts, being only in touch with an overall sense that his life is not as full as he wants it to be.

For Example:

1. As you read the dream you get a sense that someone specific is being represented in the dream, far less interchangeable than in lower categories. The dream characters are, in a global sense, believable. There is, however, very little explicit interaction of the characters in the dream and virtually no account of the thoughts, feelings or wishes of the dream characters.

2. When people do interact in the dream it is fundamentally parallel activity (everyone painting, walking, etc.) rather than much mutual, complementary interaction.

3. There will be some dreams in this category in which no people appear, but in which some inanimate object will have object-like properties. Or, something about the setting (its detail, degree of differentiation, the presence of things done by people or made by them, etc.) which contains or implies this level of object representation capacity.

Sample Dreams:

I was in an apartment where apparently I lived. I lived there with several people but J. is the only one I can remember. We had a fight. He decided that he would move out. He took all of his stuff, and all of his books, many of which were mine. I was so relieved that I didn't even notice about the books till later. He had a small electric saber saw that he was cutting up the bookshelves with. Then he left;

and I got an electric skillsaw, a considerably bigger one, and did the same thing. Someone asked me why I did this, and I said that it was because the saw J. had used was not big enough.

(The following dream is particularly illustrative of Criteria 3.) The dream concerns the nursery school I went to when I was 3 and 4 years old. I am coming back to it as an adult. In real life I have a violin and a classical guitar. Dream scene is at the nursery school and I am trading my violin with someone for a better one. I then play the instrument--much better than in real life. I then pick up my guitar and play it beautifully, though I don't know how to play it in real life and am afraid to try. Then I see myself in the house of the nursery school. I note the nice children's toys on the shelves. The house has many connecting rooms (as in real life) and the wood of the walls and floors is very interesting because it forms patterns. Very thin planks of wood. There are objects covered with tarpaulin. Someone says the school is closed up now. The little children don't come there anymore. I think about the planks--how beautifully they decorate the place.

7. The subject experiences people with a good deal of sensitivity and acuity. They are unique, varied and rather well defined for him. He is aware of important, subtle differences among people, both in terms of changes in moment-to-moment and day-to-day moods and attitudes, as well as overall differences in character of those around him. People seem to be central to the subject's inner life, even if neurotic conflicts lead him to experience them in childish, transference-dominated ways. He seems to be "in touch" with people affectively.

For Example:

1. Dream characters explicitly interact with each other or with the dreamer. The thoughts and feelings of at least one character besides the dreamer are noted.

2. You get the sense that the dream characters are defined sufficiently well that you might recognize one or more of them in another dream (besides than by their names).

3. The dreams in this category as well as those in #8 are very vivid, and the relationships among the dream characters, though peppered with the absurdity of dream consciousness, is generally cogent and believable.

Sample Dreams:

I was in a large department store with my father, mother and youngest daughter. My daughter and mother had separated from dad and I, and we were just walking around, talking, and looking at various items in the store. We must have been in the hardware section, because I remember looking at certain tools, etc. My dad looked over a wheelbarrow which he felt he needed. I remember thinking that he was too old to be purchasing a wheelbarrow, as well

as the fact that he probably wouldn't be using it that much. We also looked and priced bathroom facilities, because he was thinking of adding another bathroom to his house. For some reason we did not meet my mother and daughter until we returned home (my parents'). I remember coming into the house and looking for them. My mother was in bed complaining of a headache or something, and my daughter was standing nearby. I felt that this was a way of telling me that she did not enjoy looking after my daughter in the store and that it had "got her down."

I dreamed I was getting married to a guy I know (but not all that well) named A. I know we went through the ceremony, which is rather vague to me now. What is vivid is the wedding celebration. It was a sit down dinner held in a large room of some building (probably a hotel). There were a lot of people. Before the dinner I remember throwing my bouquet to the single girls over my shoulder and yelling "byork." My sister Debbie caught it. It didn't fly far, only to her. She was in front of the group. It was a white bouquet of flowers and I was wearing a beautiful white wedding gown that made me feel beautiful and happy. I threw the flowers to the girls who were surrounded by other people and also the orchestra. . . . The next part was dancing (the next item on the agenda of a wedding reception). A. and I were to go in and "start the dancing." I picked my skirt up, gathered it together and we started walking towards the room. I then looked at A. in a quizzical fashion, asking him if I ever danced with him before, and then said, oh, yes, that one time at Margie's wedding (a real incident that did occur). I remember feeling sort of shy about the whole thing. Then we were at the entrance of the social hall and my parents were at the other side of the long hall that you had to come down before you got to the room. They were telling us to first wait for them before we began dancing. It was exciting and typically Jewish. I woke up somewhere around here . . . also I didn't know anyone at the reception. Not that they were strangers, just that they were "people."

8. The subject lives in a lively world of fully human objects. There is a sense of rapport with people and a well-developed understanding of their thoughts, feelings and conflicts. There is a well-articulated internal model of people being involved with each other, including an understanding of why they form relationships, why they get out of them, and what interferes with them. Others' behavior and personal characteristics are considered in perspective, remain open to reinterpretation, etc. There is a good deal of self and interpersonal awareness, indeed, a psychological-mindedness. Relationships are, for the most part, not neurotically conceived.

For Example:

1. A reflective comment is made in the dream report about what the dream is saying, or the self in the dream reflects during the

dream on some aspect of his feelings toward another dream character, or on some aspect of that character's conflicts. More than reporting the feelings or wishes of a dream character, the subject spells out an awareness of some conflict(s) in the character, himself or their relationship.

2. There is a creative use of humor in the dream, particularly centering around the human characters in the dream.

3. There is something particularly distinctive and subtle about a dream character noted by the subject.

4. The dream characters and their interactions seem only minimally directed by neurotic concerns. There is a maturity about the dream characters.

Sample Dream:

I dreamt I was with L., my teacher in the math section I'm in. In the dream he had this rather absurd hat on, it reminded me in the dream of something I'd seen in the circus. He came up to me and someone else who was with me, but who isn't clear, and suddenly started to deliver this serious speech about the terrible state of the economy, and then about the importance of ecology and threw in, for some reason, something about the price of clover in Britain. I asked him why he was telling me all this and he asked me if I wasn't interested and I said no, I'm not, and that he seemed not to be either, that he seemed to be trying to be a clown and serious at the same time, like he wants to clown around but is always pulling himself back to being so serious, as if he thinks it isn't right to clown around (this is something I've begun to think about this guy in real life). He seemed to hear me in the dream, but changed the subject, as if he didn't like what I'd said to him.

APPENDIX B

INTERVIEW ON ALONENESS

Demographic Data:

Age:

Sex:

Employed? In School?

Describe your living situation.

Interview points:

- Definition of aloneness: How do you use the word alone?
- Estimate of time spent alone per week: For the purposes of this section of the interview, I want to use the word alone to mean physically isolated, as in alone in your apartment, an office, your house. To get an estimate of the amount of time a week you spend in physical isolation, I need you to tell me your daily routines. Start with a weekday. A weekend day.
- Of these--hours/week, how much of that time is time you choose to be alone? If you had your way, would you spend more time or less time alone, or keep it the same?
- Are there activities you prefer to do alone?
- Have you ever gone to a restaurant unaccompanied? A movie?
- Are there times when it is important to be "semi-alone?" I.e., alone in a room with someone sitting in the next room for example. Under what conditions are you best able to concentrate on a solitary activity like writing a report, drawing, reading: when you are totally alone, when you are in a room with others nearby but not interacting, or when you are interacting with others on and off?
- How can you tell when it is time to be with people?
- How can you tell when it is time to be away from people?
- Have there been times when you felt uncomfortable because you were alone? (This wouldn't include situations when you were in physical danger.) Describe some examples. What was the situation? What were you feeling? How often does this occur? Are there any other types of uncomfortable experiences?

- What might you do when you feel _____ (use subject's term for the discomfort)?
- What type of things might you do in order to avoid aloneness? Would you attend a party at which there would be people whose company you didn't enjoy? Would you watch a mediocre television show? Do you find yourself going shopping to be among people? How many times a month do you drink or use drugs? When alone? Do you ever go to a bar by yourself? How often?
- Think of the person you spend most of your time with. What did you do last time this person was away? Activities? Feelings?
- When you are alone, generally speaking, how do you feel? What if you aren't busy?
- I want to know how aloneness affects your different moods. Let's say you were depressed, and then alone. How would being alone affect you? If you were in a good mood? Angry? Anxious or worried?
- Imagine you came home and no one was home, and by an odd circumstance, your telephone, television, and radio weren't working. What would you do; how would you feel?
- Compared to other people, how do you rate your tolerance of aloneness? Rate yourself on a scale of 1 to 5 where 1 is most tolerant of aloneness and 5 is least tolerant of aloneness.
- Can you think of anything to add that would help me to understand your experience of aloneness?

APPENDIX C

ANNOUNCEMENT TO CLIENTS

The Psychological Clinic is supporting a doctoral research project on the capacity to be alone. As an adult client of the Psychological Clinic you are eligible to participate in the study. Each volunteer will be interviewed for about an hour concerning his or her experience of aloneness. Volunteers will receive an honorarium of \$1.50 as a token of appreciation for completing the interview. Some of the volunteers will then be asked to participate further. This will involve collecting information about the person's dreams, earliest memories, and responses to some test pictures. An additional honorarium of \$6.00 will be presented to those individuals participating in this part of the study.

This research project will be conducted separately from your therapy. Your decision whether to participate will not affect your therapy. If you do decide to participate, your therapist will then be asked to rate your tolerance of aloneness on a rating scale. This is the only communication that will occur between your therapist and the researcher. The researcher will not discuss any of your responses or results with the therapist, unless you specifically request it. All information will be considered confidential.

Please check the appropriate box below:

_____ Yes, I would consider participating in the study

_____ No, I would not consider participating in the study

If yes, please provide the following information:

Name: _____

Phone Number (s) _____

Best times to call _____

APPENDIX D

STATEMENT OF INFORMED CONSENT

This research project is designed to test some theoretical views on people's experiences of aloneness. I will be interviewing you about your experiences alone. This will last approximately an hour and I will pay you \$1.50 as a token of appreciation upon completion of the interview. You are free to withdraw consent or stop participating in the interview at any time; withdrawal from the experiment will not affect your treatment in any way. You are in no way obligated to your therapist to complete the interview or to participate in any way. Your therapist will not be informed of your results. You have the right to ask questions about procedures at any point, and I will try to answer your questions. With your permission, I will ask your therapist or group leader to rate your tolerance of aloneness on a rating scale, if they have a basis for judgment. This is the only topic I will ask about and the only issue your therapist has permission to discuss. Measures will be taken to ensure the confidentiality of the information you tell me. I will label your statements with a code number rather than your name. If I were to quote you in my findings, I would alter or leave out any details which could conceivably identify you.

If you are selected for participation in further study, I will spend another session with you, which will take about one to three hours. At this time I will ask about your earliest childhood memories, and I will ask you to respond to some test pictures. You will be asked to record your next five dreams over the next several weeks. If you are selected for this phase of the research, you will receive \$6.00 as a token of appreciation upon completion. The same procedure stands as described above with regard to your right to stop participation without consequence and your right to strict confidentiality.

The results of the study will be made available to any subject who requests them. If you leave your name and address for that purpose, I will send you a summary of results when the study is completed.

I have read the statement of informed consent and understand it.

Signed: _____

Date: _____

Witness: _____

I authorize my therapist or group leader _____ of _____ to rate me on a tolerance of aloneness rating scale and to release this information to Susan Feinberg, the experimenter, within three months of this date.

Signed: _____

Date: _____

Witness: _____

I give permission to Susan Feinberg, the experimenter, to contact me at the following phone number(s) _____ or address _____ to notify me of selection into the second phase of the study and, if selected, to discuss progress on dream reports.

Signed: _____

Date: _____

Witness: _____

Experimenter:
Susan Feinberg
1516 Highland Avenue, #5
Knoxville, Tennessee 37916
546-7959

APPENDIX E

RATING SCALE FOR TOLERANCE OF ALONENESS

High Tolerance:

Any discomfort related to aloneness is

1. Not severe or disabling, but usually described as a need to communicate an idea to a friend or a desire to share an experience.
2. Not accompanied by a sense of urgency, desperation, or physical tension.
3. Handled by direct, selective, or productive coping styles. Examples: phoning a friend, "sitting with" discomfort, using time productively.

Subject is usually relaxed and comfortable when alone, even when aloneness is not chosen. Subject can usually be comfortable when alone whether busy or not. Moods may intensify when alone to the point that the subject may seek other's company, but there is never any real urgency to do so. Subject is likely to attend movies or restaurants alone without discomfort.

Average Tolerance:

Subject does not complain of regular discomfort when alone, but may admit to feelings of restlessness, cabin fever, or low-grade anxiety which do not interfere with structured activities (work, classes, homework, regular housecleaning). No panic is noted. To reduce mild anxiety or restlessness, the subject may telephone or visit a friend, seek activity, overeat on an occasional basis, use radio or television on an occasional but not daily basis.

Subject is unlikely to consider tolerance of aloneness a problem, though he/she may structure life so that it is not frequently tested. Subject would be likely to feel uncomfortable (loose ends, restless, lonely, anxious) to be alone several hours without a project or access to a phone, TV, or radio. Means of coping with discomfort are not self-destructive, but may not be particularly productive, direct, or selective.

Low Tolerance:

Discomfort is noted at times when alone. It may be described as loneliness, anxiety, nervousness, fear, boredom, or panic. There may be an urgency to make or plan contact or to find relief. This urgency may prompt impulsive, unselective, and even self-destructive actions. Coping with alone time may involve:

- Stimulation seeking (driving, routine use of radio or TV).
- Unselective social activity (heavy partying, phoning down a list of names, sexual promiscuity including one-night stands, toleration of an abusive relationship, reliance on pets).
- Avoidance of alone time by sleeping or overworking.
- Use of alcohol, drugs, or food for relief. (Overeating leading to weight gain.)

The subject is likely to have problems managing time alone. The subject may think of it as time to "fill up" or "get through" and may have trouble concentrating when alone. The subject is unlikely to go to a movie or restaurant alone.

APPENDIX F

SCALE FOR SCORING OBJECTS RELATIONS TECHNIQUE

1. Degree of projection and enlivenment
 - 0 - card description
 - 1 - minimal enlivenment, action, or explanation of motivation. Factual, but goes beyond card description. Unspecified precedents such as "has a problem."
 - 2 - story with some sense of action and enlivenment
 - 3 - involved, detailed projection
2. Character description
 - 0 - no characters, or characters dead or nonhuman.
 - 1 - male, female, person
 - 2 - role description or single descriptor with "person"; father, daughter, judge, old man
 - 3 - further description than role, tending toward multidimensional description
3. Description of physical setting
 - 0 - no description of setting
 - 1 - brief statement of facts: a table and chair
 - 2 - more descriptors of unidimensional nature: an old chair
 - 3 - detailed description of environment
4. Degree and complexity of interaction
 - 0 - no interactions
 - 1 - parallel activity (two people walking), comments on lack of fulfilling interaction
 - 2 - stereotyped interaction, but more than parallel activity
 - 3 - complexity in the interaction (complex feelings, conflict is described with some psychological understanding)
5. Valence of interactions
 - 2 - clearly malevolent or threatening (a robber, a witch)
 - 1 - sense of negative or unfulfilled interaction
 - 0 - neutral
 - +1 - sense of a positive interaction
 - +2 - distinctly positive, nurturing, giving, loving interactions
6. Valence of physical environment
 - 2 - clearly malevolent, spooky
 - 1 - sense of negative (dirty room)
 - 0 - neutral
 - +1 - sense of positive
 - +2 - distinctly positive environment

VITA

Susan Carol Feinberg was born February 16, 1954 in Oakland, California. She obtained her B.A. from Earlham College, Richmond, Indiana, in 1976, before beginning the graduate program in clinical psychology at The University of Tennessee, Knoxville. In 1979-1980, she interned at Yale University, working and training at Waterbury Hospital. Ms. Feinberg has worked as a therapist and psychological examiner at various settings, including Birth Defects Evaluation Center, Tennessee's Department of Correction juvenile classification program, and St. Mary's Alcoholism Treatment Unit.