RELATIONSHIP OF SOCIAL ISOLATION TO PSYCHOTHERAPEUTIC
DRUG USE IN THE ADULT

by

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STATEMENT BY AUTHOR

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The purpose of this study was to determine if a relationship existed between social isolation and psychotherapeutic drug use in the adult. Thirty subjects, 15 females and 15 males, participated in the study. Ten respondents stated that they took psychotherapeutic drugs daily or nearly every day; the psychotherapeutic drugs used were either tranquilizers, sedatives, or hypnotics.

The data indicated that those people who took psychotherapeutic drugs regularly had a lower mean score for social involvement than did those individuals who did not take these medications regularly. More females than males took these drugs, and also non-married subjects used them more than the married respondents. Ninety per cent of those who took psychotherapeutic drugs regularly reported some disability. The majority of those who used the psychotherapeutic drugs on a regular basis felt their present health was either poor or very poor, and they stated their health had worsened over the past five to ten years.

The recommendation given in this study for revisions and additions are designed to further help the health care provider to maintain the optimal degree of wellness for the older adult.
CHAPTER 1

INTRODUCTION

It is now recognized that the number of new psychotherapeutic compounds produced rises each year and there is every indication that this will continue in the future. There has also been a marked increase in the number of psychotherapeutic drugs prescribed and taken. The number of American adults who have used one or more of these drugs is difficult to determine; however, it has been estimated that one out of four adults has taken them (Parry 1968).

There is no single factor which explains this rise in drug usage. One important point Ray (1972:5) brought out is that "... drug taking is a behavior." Because of this fact, "... this behavior persists when it either increases the individual's pleasure or reduces his discomfort."

Balter (1974) thought that most drug use is a matter of choice and it is accompanied by a benefit-risk ratio and a cost-benefit ratio in terms of personal and social consequences.

Within recent years, there has been a growing concern about the rise in the use of drugs and the emergence of the drug culture. Josephson and Carroll (1974) reported that many nations of the world look upon drug use as a major
social problem. People are worried about the effects of drug taking on our society. Mellinger et al. (1974:334) pointed out in a discussion of a survey conducted that many people think that "... the widespread use of psychotherapeutic ... drugs both foretells and contributes to a major breakdown in American moral character."

Health professionals are also disturbed about the drug ingestion habits of people. The actual amount consumed is difficult to determine, yet it was brought out by Blackwell (1973:1640), after studying one substance, diazepam, that its rate of increased usage is so rapid as "... to invite questions of overuse, misuse or abuse."

Another problem of these drugs is the possible dependence on them. Older individuals who are accustomed to ingesting psychotherapeutic drugs have been observed by this nurse and other personnel after they were hospitalized and taken off of these medications for various medical reasons. A significant number demonstrated agitation and restlessness during the day and inability to sleep at night. Grand mal seizures, probably due to the withdrawal of these drugs, had also been seen in the older adult.

There are several concerns identified in the literature about the use of psychotherapeutic drugs. Rogers (1971:18) stated that one of the dangers of psychotherapeutic drugs is psychological dependency: "... people often continue to use a drug after it has served its
immediate purpose because they are uneasy about giving it up and relying on their own resources." Josephson and Carroll (1974) pointed out that those who take drugs are also worried about the consequences of their actions. A study by Blum and associates (1969) seemed to support this when it concluded that high drug users more often expressed concern about becoming dependent on drugs than did low users.

One study showed that people believed another danger with psychotherapeutic drugs is that they "... may mask symptoms or reduce motivation to change, thus interfering with the solution of underlying problems ..." (Manheimer et al. 1973:1252). Lennard et al. (1971) stated that it is known that the psychotherapeutic drugs can help to reduce anxiety, depression, and unhappiness that one may experience but they do not really deal with the source of these feelings.

In older people, one source of these feelings may be social isolation. Smith (1973:147) stated that for too many individuals in this age group, "... life has descended to a pit of loneliness." Busse and Pfeiffer (1977: 161) identified social isolation as one of several "social pathologies" which arise in some older people. They go on to say that if this situation is not changed by appropriate intervention, it may eventually result in a more enduring form of psychopathology.
These are some of the major concerns of people about the use of psychotherapeutic drugs and the occurrence of social isolation in the older adult. There seems to be an increased awareness that isolation is closely linked to a person's life satisfaction. It is also recognized that even though psychotherapeutic drugs do play a significant role in the treatment of many conditions, their use can also create new problems or aggravate existing conditions.

Statement of the Problem
What is the relationship between social isolation and psychotherapeutic drug use in the adult?

Significance of the Problem
Psychotherapeutic drugs are an important part in the medical management of individuals; yet this treatment has been found to have many untoward and dangerous effects. One of the more undesirable side effects of the psychotherapeutic drugs is that they can reduce one's desire to interact with other people (Rogers 1971). A study by Learoyd (1972:1133) showed "... the disinhibiting effect of many of the sedative drugs which resulted in greater agitation and loss of emotional control. ..." These effects have special importance when the possible influence of social isolation is related to drug use.

The dangers of drugs are also of major importance. One study showed that in 80.9 per cent of those people over
59 years old who sought emergency room treatment for some type of acute drug reaction, either the misuse or abuse of a legal psychotherapeutic drug was involved (Petersen and Thomas 1975). Another major problem with the adult taking these drugs is the higher risk in both mortality and morbidity for the older individual (Fann and Maddox 1974).

Possible abuse of psychotherapeutic drugs is now being studied. At this time, the number of older people who are dependent on drugs has not been determined. Pascarelli (1974:110) pointed out that the "... exposure to numbers of psychoactive pharmaceuticals enhances the likelihood of the problem." It has been demonstrated that both psychological and physiological dependence has occurred with these drugs. Barbiturates have proven to be addicting drugs (Gold and Zimmerli 1973). One study of non-narcotic drug abusers concluded that the majority of patients in the study "... became addicted while being legitimately treated for an undefined anxiety, stress or depression" (Moffett and Chambers 1970:57).

The problems the older individual encounters with socializability has been discussed by several authors. Rosow (1974) pointed out that the older individual is excluded from equally participating in social activities with subsequent role loss. He says for many, this loss of role is mainly involuntary and unwelcomed. In addition, of all life stages, old age is the only one which has systematic
social losses rather than gains. Smith (1973:148) goes on to say that as one's number of companions lessens, the older person may withdraw inside of himself and may then just "... fall from sight."

The importance of accurately assessing social isolation was brought out by Busse and Pfeiffer (1977:162). They pointed out that social isolation is an "... entirely remedial situation...", if it is correctly identified and proper measures are taken to alleviate the situation.

This study will attempt to identify the relationship of social isolation to psychotherapeutic drug use. If this relationship is determined, it may aid the health care providers to recognize factors and assess situations which could influence both social isolation and psychotherapeutic drug use. This information may contribute toward helping the older adult maintain his maximum degree of wellness.

Conceptual Framework

Five factors were identified in the literature which pertain to social isolation and psychotherapeutic drug use; these will be discussed in the conceptual framework. The factors are: age, sex, marital status, education, and disability (see Figure 1).

As people age, it is speculated that social isolation increases (Kutner et al. 1956). One reason for this was brought out by Thomas (1970:14) who stated that
Figure 1. Schematic representation of the conceptual framework.
"environmental losses, such as the disruption or loss of major social roles . . . may not be avoided" in later years of life. Older individuals may frequently experience the death or moving away of family and friends.

Both men and women experience an increase in social isolation as they grow older. Thomas (1970:33) gave one explanation when she brought out that "widowhood for women seemed parallel to retirement for older men with respect to loss of a primary role . . . and difficulty in maintaining and replacing relationships."

The drug ingestion habits of the older adult have been researched and described in the literature. Stolley et al. (1972) concluded in their study that the elderly accounted for a disproportionate amount of drug usage, including the psychotherapeutic drugs.

It is known that both older men and women take a significant proportion of drugs, but there is a difference in their drug habits. Manheimer et al. (1974) found that, for men, there was a marked rise in the use of psychotherapeutics after the age of 60. Rogers (1971) pointed out that women, throughout all age groups, consistently take more drugs than men. This may be due to differences in our society concerning ways the two sexes seek relief from stress and anxiety (Ray 1972).

Marital status seems to play a definite role in social isolation, especially with the elderly. Gubrium
said that being married "is a status which maintains a continuity in social engagements in old age relative to an earlier life." "Becoming widowed . . . produces a discontinuity in it." Marital status had been related to drug use but Manheimer, Mellinger, and Balter (1968:449). They found that married individuals took fewer psychotherapeutic drugs than did those who had experienced some disruption in their marital status, as for example, the death of a spouse.

A positive correlation between the amount of education one has received and the number of social roles in which he had participated was found by Clark and Anderson (1967). This would suggest that the better educated person may experience less social isolation. Also, one study looked at the education of a person in regard to drug ingestion, and it concluded that the better educated did not demonstrate a pattern of taking more psychotherapeutic drugs than did those with less education (Parry 1968).

It is recognized that the older adult experiences more disabling conditions and with greater frequency than other age groups (Strauss 1975:2). According to Black (1973) disability can eventually result in a person withdrawing from others. It has been suggested that physical disability may predispose the elderly person to use a significant amount of psychotherapeutic drugs (Pascarelli
1974). He thought this results because a disability will subject the individual to stress.

The above studies seem to suggest a relationship between social isolation and psychotherapeutic drug use when certain factors are examined.

Definitions

The following terms were defined for use in this study.

1. Psychotherapeutic drugs--refers "... to those mood changing drugs that (a) are used as medicines to alleviate psychic distress, or as adjunctive treatment for various physical disorders; and (b) are typically acquired through a doctor's prescription or over the counter at a drugstore" (Mellinger et al. 1974:333). These include any of the following: major and minor tranquilizers, sedatives, anti-depressants, hypnotics, and stimulants.

2. Drug use--the number of times a person takes one or more psychotherapeutic drugs within a given period of time.

3. Over-the-counter drugs--"those ... intended for temporary medication of minor illnesses and are considered safe for use without a physician's supervision if the instructions on the label are followed carefully" (Ray 1972:12).
4. Social isolation—a condition in which there is a "... limited range of interpersonal relations" (Kutner et al. 1956:110).

5. Older adult—those individuals 50 years and older.

**Assumptions**

The assumptions include the following:

1. Social isolation can be measured by a structured interview.

2. Drug usage over a state period of time can be obtained by a structured interview.

**Limitations**

The limitations included the following:

1. The size of the sample was limited to 30 subjects.

2. Participants included in the sample were 50 years and older.

3. Subjects in the sample were able to read and speak English.
CHAPTER 2

SELECTED REVIEW OF THE LITERATURE

Five major areas were identified in the literature as having a probable relationship to both social isolation and psychotherapeutic drug use. These were: age, sex, marital status, education, and disability.

Social Isolation

Social isolation is defined as a condition in which there is a "limited range of interpersonal relations" (Kutner et al. 1956:110). This definition was expanded by Black (1973) to include both a sensory deprivation along with a lack of self-actualizing experiences. Kutner et al. (1956) pointed out that a major problem facing the older adult is that he finds it increasingly more difficult to acquire new friendships which are comparable to those he enjoyed for the greater part of his life. Yet, it is possible, Hoffman (1970) believed, that the older individual can either form or reestablish a variety of social relationships and patterns of social participation if only given the opportunity.

Social isolation can occur in any age group as a result of numerous factors. It is more prevalent in the older adult and for this reason, studies have looked
carefully at this segment of the population. Weiss (1973: 150) stated "the aged, like the rest of us, require the provisions of the social relationships, but more than the rest of us stand in risk of losing relationships to death or to the vagaries of their own, their friends' or their childrens' changing circumstances."

The importance of social interactions with significant others has been repeatedly emphasized. Field (1972: 142) postulated that a factor important to the older adult is not necessarily the number of friends and relatives who may visit, but "... the significance of the particular visitor to the elderly person." It is believed that as one grows older, social interaction gains importance as a means of self-validation (Gubrium 1976). The statement by Black (1973:577) that "the individual identity of each human person is gradually built up and continually supported by communication with other persons" seems to reinforce this view.

Even though it is difficult to identify those factors which could create social isolation, Townsend (1973) stated that those who are most socially isolated have experienced a combination of three or more of the following: living alone, being in the older age group, living some distance from children and relatives, being retired from work, and experiencing some infirmity.
It is also believed that changing social roles play an important part in causing social isolation. Hoffman (1970) pointed out that the older person is generally roleless when compared with other individuals. Social regulations, illness, or death of a spouse can remove this person from the primary social roles he has known and as a consequence, many of his secondary role attachments are also gone. Regardless of the cause of social isolation, it inevitably removes the gratification of sociability and social activities; "... it very directly impoverishes life" (Weiss 1973:150).

One factor which seems to be closely related to social involvement is the age of the individual. Kutner et al. (1956) pointed out that there is a sharp decline in social interactions occurring after the age of 75. They go on to say that even though both men and women experience a general downward trend in social relationships as they grow older, men in their retirement years of 65 to 69 seem to experience a sudden drop in social contacts. Gubrium (1976) stated that the older person often finds that occupational retirement is followed by a reduced income, lessened physical activity, diminished energy, and a constriction of the social world through the death of a spouse, sibling, or close friend.

It is recognized that men experience a reduction in social relationships as a result of retirement. The
importance of the work role for males in relation to both
direct and indirect social participation was stressed by
Hoffman (1970). He believed work provides a social
"anchorage" to men and through them to their families.
Field (1972) added that as men retire, they are often then
forced into associations with only those in their own age
group which might result in these people becoming separated
from community life.

It is believed that as the individual grows older,
he may become more involved in attending to himself, re-
sulting in the avoidance of him by others. Kalish (1972:
87) stated this occurs because the older person recognizes
"... the increasingly limited duration of his futurity."

Both men and women see a marked decline in their
social roles as they grow older. Women more often than men
experience a reduction in their social interactions as the
result of the loss of a spouse (Hoffman 1970). She went on
to say that 46 per cent of women between the ages of 65 to 74
are married as compared to 79 per cent of the men.

Marital status can also influence the amount of
social interaction the person enjoys by affecting "... the
quality of a wide range of interpersonal ties between the
individual and his associates (Gubrium 1974:107). He also
believed that everyday routines are often supported by a
spouse, and when this person is no longer present for such
help, there can be rather severe changes in these routines, possibly resulting in a reduction of social participation.

The effects occurring as the result of the death of a spouse were brought out by several authors. Levine (1969: 30) stated this not only resulted in reduced social interaction but also in disengagement and demoralization. Bereavement for a loved one is considered by Weiss (1973) to be the most important cause for loneliness. This view seemed to be supported by Clark and Anderson (1967); they found that women who more often verbalized a feeling of loneliness were generally widows.

It appears from these data that age, sex, and marital status are closely interconnected and must be considered as major factors that may have an influence on social isolation.

Clark and Anderson (1967) felt that education is positively related to the amount of social interaction a person experiences. Johnson (1976) in a recent study stated that her data indicated that social isolation scores increased in subjects as their number of years of schooling decreased.

**Disability**

Disability may result in lessened endurance, decreased mobility, speech or hearing losses, or bodily disfigurements. The disabled person may have to spend so much
time on a treatment regimen that he has no time or energy to be with friends. As a result, social relations may become changed, limited, or disintegrate as the person pulls away from or loses contact with others Strauss (1975: 54).

Garrard and Bennett (1971:97) stated that the severity of the disability is proportional to the degree of dependency it creates. This dependency of the older person may be difficult for him to accept, especially when it means he must rely on his children for help. Field (1972:127) pointed out that this may cause a role reversal for the adult and "... threatens the maintenance of accustomed relationships." It is felt that any situation which leads to a loss of contact with significant people in a relationship can lead to social isolation (Weiss 1973).

Kalish (1972) and Strauss (1975) brought out that the problems often found with chronic conditions can make the person introspective and persuade those around him to withdraw from him. Bartlett (1961) discussed that some individuals cannot adjust to the changes in their role which are the results of physical limitations. It is believed that as disability increased, there was a definite reduction in the social roles one had experienced at a younger age (Clark and Anderson (1967). Disability can cause a person to use up vital energy which might have been spent among friends (Strauss 1975). There may also be a general decline in
health and mobility accompanying some chronic disabling conditions (Gubrium 1976).

**Psychotherapeutic Drug Use**

Numerous surveys have been conducted to determine the types and amounts of drugs which are taken and the relationships of these to various individual factors. This study looked at only those psychotherapeutic drugs used by adults.

The age of the individual is related to both the types of psychotherapeutic drugs taken and the amounts ingested. Manheimer et al. (1968) and Warheit, Arey, and Swanson (1976) found that the use of sedatives increased with age. Manheimer et al. (1968) reported that there are two peak periods for women using tranquilizers, in their thirties and again in their fifties. He also stated that men were more likely to report the use of stimulants in their thirties, tranquilizers in the forties and fifties, and sedatives from age 60 on. Ray (1972:13) explained these findings by saying that tranquilizers are taken in the middle years to help deal with the problems occurring with growing children and the attempt to get established in a work role. After age 60 "... rather than just take the nervous edge off of living, it is preferable to blot it out with drugs."
A study on the number of prescriptions presented to a community hospital was done by Stolley et al. (1972). This showed that the older person, especially women, "... accounted for a disproportionate amount of drug use." This was true for many types of medications, including psychotherapeutics.

The marital status of a person has also been related to drugs. Manheimer et al. (1968:449) and Borgatta (1974:118) found that separated or divorced persons were likely to report more frequent use of psychotherapeutic drugs, especially tranquilizers, than were married or single persons. Webb and Collette (1975) reported that there was an increased use of these drugs in households where persons lived alone; although this study did not look at the marital status of these people.

Another important variable in drug use is the sex of the person. It was brought out by Parry (1968), Rogers (1971), Warheit et al. (1976), and Stolley et al. (1972) that women take about twice as many psychotherapeutic drugs as men. Manheimer et al. (1974) pointed out that women buy about the same number of over-the-counter psychotherapeutics as men; therefore, the difference in the amount results because far more women than men take medically prescribed drugs.

The relationship of disability to drug use has been studied to a limited extent. Pascarelli (1974:109) stated
that physical disability caused increased stress in the older adult and this may cause him to abuse psychotherapeutic drugs.

Social isolation has not been directly related to drug use. Both Bartlett (1961) and Pascarelli (1974) identified isolation as being very stressful; and it was concluded in a study by Manheimer et al. (1974) that stress is positively related to psychotherapeutic drug use. The literature has identified some of the same factors to be positively related to both social isolation and psychotherapeutic drug use.
CHAPTER 3

DESIGN OF THE STUDY

This was a correlational descriptive study designed to seek the answer to the question: What is the relationship of social isolation to psychotherapeutic drug use in the adult?

Method of the Study

Social isolation was determined by a structured interview whereby each individual was asked questions concerning his social involvements. Each respondent was also asked questions regarding the types of psychotherapeutic drugs he was taking and the frequency of use during specific periods of time.

The Sample

The sample consisted of 30 consenting subjects from the offices of seven physicians in a southwestern city. They were ambulatory outpatients living at home, between the ages of 54-80, and able to read and speak English.

Method of Data Collection

Permission to conduct this study was obtained from The University of Arizona Human Subjects Committee (see Appendix A). Written permission was obtained from all
subjects who met the criteria (see Appendix B). Each person was told that an interview would be scheduled by the researcher which would last about one hour. Interviews were conducted in the offices of the seven physicians, either before or after the subjects were seen by the doctor. All participants were told that the study was confidential, no names would be used, and all data would be grouped and coded for computer analysis. Those interviewed were told that they might refuse to answer any questions and/or withdraw from the study without any effect on their relationship with the physicians or staff of the doctors' offices. They were given the opportunity to obtain an abstract of this study.

Measurement Instruments

The instrument used for measuring social isolation was a scale developed by Thomas (1970) designed to determine social involvement (see Appendix D). Social involvement as defined by Thomas takes into account those contacts, either direct or indirect, which a person has with his environment. This would include a one-to-one contact, formal or informal organizational activity, or those of a solitary nature. The scale is a 45-item index which includes leisure time activities, group membership and participation, interactions with friends and relatives, and other factors important to socializability, such as marital status. A change in social
participation was determined by a question on any changes in frequency of activity within the past five to ten years.

Thomas (1970) measured reliability of the scale by a test-retest reproducibility at \( r = 0.76 \). Face validity and concurrent validity were also measured \( (r = 0.64 \text{ and } 0.53) \).

A modified questionnaire, used by Manheimer et al. (1968) in a California survey was utilized to determine psychotherapeutic drug use (see Appendix E). These questions refer to stimulants, sedatives, hypnotics, and tranquilizers. For any positive answer, the respondent was then asked about the regularity of taking the medication and the last time one of these drugs was taken. Both prescription and over-the-counter drugs were considered. There was no measure of reliability or validity on Manheimer et al.'s scale.

The scale for social involvement was designed for the older adult; therefore, it is appropriate for the population considered in this study.

**Analysis of the Data**

The data were coded and submitted for analysis. The Pearson product moment correlation coefficient was used to indicate the magnitude and direction of any relationships between the independent and dependent variables. Multiple regression analysis determined the strength of the relationships between the variables. The .005 level of significance was used. Chi-square was used as a test of
significance on the data collected from the 10 patients who took psychotherapeutic drugs on a regular basis. The .005 level of significance was used.
CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

This study was designed to answer the question: What is the relationship of social isolation to psychotherapeutic drug use in the older adult.

Characteristics of the Sample

The findings of this study were based on a sample of 30 subjects who met the criteria of the study. All subjects were ambulatory outpatients who were seeing a physician for a medical problem.

There were 15 males and 15 females in the sample. Their ages ranged from 54-80 years with a mean of 67.7 years. The age group of 65-69 years has the largest majority of subjects, seven males and six females. The age groups of 75-80 and 60-64 each contained six participants. One male and one female were in the 54-59 group and three respondents were in the 70-74 range (see Table 1).

In this study, 93 per cent of the male subjects and 46 per cent of the female participants were married. Two of the respondents were divorced, one female subject was single, and there were six widows (see Table 2).
Table 1. Characteristics of Subjects by Age and Sex

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Per cent</th>
<th>Female</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>54-59</td>
<td>1</td>
<td>6.66</td>
<td>1</td>
<td>6.66</td>
</tr>
<tr>
<td>60-64</td>
<td>2</td>
<td>13.33</td>
<td>6</td>
<td>26.66</td>
</tr>
<tr>
<td>65-69</td>
<td>7</td>
<td>46.66</td>
<td>6</td>
<td>40.00</td>
</tr>
<tr>
<td>70-74</td>
<td>1</td>
<td>6.66</td>
<td>2</td>
<td>13.33</td>
</tr>
<tr>
<td>75-80</td>
<td>4</td>
<td>26.66</td>
<td>2</td>
<td>13.33</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.00</td>
<td>15</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Table 2. Marital Status of Subjects by Sex

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Male</th>
<th>Per cent</th>
<th>Female</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>14</td>
<td>93</td>
<td>7</td>
<td>46</td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100</td>
<td>15</td>
<td>100</td>
</tr>
</tbody>
</table>
The education of the participants ranged from 8-16 years attended in school, with a mean of 11.3 years. The majority of the subjects attended high school (see Table 3).

Table 3. Characteristics of Subjects by Education.

<table>
<thead>
<tr>
<th>Education</th>
<th>Number of Subjects</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade school</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>High school</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>College</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>Graduate</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

Seventy per cent of the subjects stated that they had a disability; 12 of these were males and nine were females. Seven individuals stated that they had two disabilities and nine participants reported none. The largest percentage of those who had a disability were in the 65-69 year age range (see Table 4). The disabilities of the respondents were varied: five subjects stated they had emphysema, four reported asthma and arthritis, and three said they had a CVA. Twelve other disabilities were also identified by the respondents (see Table 5).
Table 4. Distribution of Subjects with Disability by Age and Sex

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Per cent</th>
<th>Female</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>54-59</td>
<td>1</td>
<td>8.33</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>60-64</td>
<td>1</td>
<td>88.33</td>
<td>2</td>
<td>22.00</td>
</tr>
<tr>
<td>65-69</td>
<td>6</td>
<td>50.00</td>
<td>5</td>
<td>56.00</td>
</tr>
<tr>
<td>70-74</td>
<td>1</td>
<td>8.33</td>
<td>2</td>
<td>22.00</td>
</tr>
<tr>
<td>75-80</td>
<td>3</td>
<td>25.00</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100.00</td>
<td>9</td>
<td>100.00</td>
</tr>
</tbody>
</table>
Table 5. Disabilities Reported by Subjects (N = 21)\textsuperscript{a}

<table>
<thead>
<tr>
<th>Number of Subjects Reporting a Disability</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>CVA—with either residual weakness or decreased use of extremity</td>
</tr>
<tr>
<td>5</td>
<td>Emphysema</td>
</tr>
<tr>
<td>4</td>
<td>Asthma</td>
</tr>
<tr>
<td>4</td>
<td>Arthritis</td>
</tr>
<tr>
<td>1</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>1</td>
<td>Osteomyelitis</td>
</tr>
<tr>
<td>1</td>
<td>Tendonitis—with reduced movement of joints</td>
</tr>
<tr>
<td>Cardiac Problems</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Angina</td>
</tr>
<tr>
<td>1</td>
<td>Post myocardial infarction</td>
</tr>
<tr>
<td>1</td>
<td>Post open-hart surgery</td>
</tr>
<tr>
<td>1</td>
<td>Diabetes—with complications</td>
</tr>
<tr>
<td>1</td>
<td>Multiple myeloma</td>
</tr>
<tr>
<td>1</td>
<td>Leukemia</td>
</tr>
<tr>
<td>1</td>
<td>Organic brain syndrome</td>
</tr>
<tr>
<td>1</td>
<td>Pernicious anemia</td>
</tr>
<tr>
<td>1</td>
<td>Weakness in legs—cause unknown to subject</td>
</tr>
</tbody>
</table>

Total 28

\textsuperscript{a}Seven subjects reported two disabilities.
Findings Related to the Conceptual Framework

In the conceptual framework, it was stated that there may be a relationship between social isolation and psychotherapeutic drug use in the older adult when common factors are examined. The measurement tool, Thomas's (1970) questionnaire on social involvement, rated each response with a set numerical value. The investigator then totaled the number of points to be used as an indicator of social isolation.

Both a factor analysis and a scattergram of the activity scale were done. Because no significant correlation or linear relationships could be determined between the variables, a correlational coefficient could not be computed (Downie and Heath 1974). A total score for the social involvement scale was obtained only to determine the mean of the score and not to measure the relationships between social isolation and the other variables.

Thirty-three per cent of the subjects stated that they took psychotherapeutic drugs on a regular basis. The mean level of social involvement score for these individuals was 64.3. Sixty-seven per cent of the subjects stated they did not take psychotherapeutic drugs or took them very infrequently. The mean level of their social involvement score was 76.7. In this study, the lower score indicated that those people who took psychotherapeutics on a regular
basis were less socially involved than were those participants who did not take these drugs on a regular basis.

In the conceptual framework, it was stated that several factors may have an influence on psychotherapeutic drug use. As one grows older, an individual may take more psychotherapeutic drugs than a younger person. Women seemed to take more of these drugs than men. It was thought that a disability or change in marital status may cause an increased use of psychotherapeutic drugs. The better educated do not seem to take more psychotherapeutic drugs than the less educated.

The correlation coefficients between these five common factors—age, sex, education, marital status, and disability—are summarized in Table 6. Only correlations at the .005 level of significance will be considered.

No relationship was shown between these factors and psychotherapeutic drug use. This may be due to the low percentage of individuals who take psychotherapeutic drugs on a regular basis.

A list of the characteristics of the ten individuals who took psychotherapeutic drugs regularly is presented in Table 7. The statistical test, Chi-square, was used with these data to determine if these distributions differ from a predetermined theoretical distribution, that which would be expected to occur by chance (see Table 8).
Table 6. Correlation Between Common Factors and Psychotherapeutic Drug Use

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.0000</td>
<td>.1006</td>
<td>-.3112</td>
<td>.2116</td>
<td>-.1171</td>
<td>.2485</td>
<td>.0337</td>
<td>.0190</td>
</tr>
<tr>
<td>Sex</td>
<td>.1006</td>
<td>1.0000</td>
<td>.1214</td>
<td>.1750</td>
<td>-.4666</td>
<td>.1985</td>
<td>-.0421</td>
<td>-.3007</td>
</tr>
<tr>
<td>Educ.</td>
<td>-.3112</td>
<td>.1214</td>
<td>1.0000</td>
<td>.2229</td>
<td>.1734</td>
<td>-.0843</td>
<td>.1447</td>
<td>.0568</td>
</tr>
<tr>
<td>Dis.</td>
<td>.2116</td>
<td>.1750</td>
<td>.2229</td>
<td>1.0000</td>
<td>-.0476</td>
<td>.1216</td>
<td>.0172</td>
<td>.1455</td>
</tr>
<tr>
<td>M.S.</td>
<td>-.1171</td>
<td>-.4666</td>
<td>.1734</td>
<td>-.0476</td>
<td>1.0000</td>
<td>-.1216</td>
<td>-.1892</td>
<td>.0364</td>
</tr>
<tr>
<td>Stim.</td>
<td>.2485</td>
<td>.1985</td>
<td>-.0843</td>
<td>.1216</td>
<td>-.1216</td>
<td>1.0000</td>
<td>.3366</td>
<td>-.0928</td>
</tr>
<tr>
<td>Sed.</td>
<td>.0337</td>
<td>-.0421</td>
<td>.0447</td>
<td>.0172</td>
<td>-.1892</td>
<td>.3366</td>
<td>1.0000</td>
<td>.3152</td>
</tr>
<tr>
<td>Tran.</td>
<td>.0190</td>
<td>-.3007</td>
<td>.0568</td>
<td>.1455</td>
<td>.0364</td>
<td>-.0928</td>
<td>.3152</td>
<td>1.0000</td>
</tr>
</tbody>
</table>

*aSignificant at .005.
Table 7. Characteristics of Subjects Who Took Psychotherapeutic Drugs Regularly

<table>
<thead>
<tr>
<th>Subject</th>
<th>Age</th>
<th>Pres. Health</th>
<th>Chg. in Health</th>
<th>Health Related to Others</th>
<th>Part. in Act.</th>
<th>Part. in Groups</th>
<th>Sex</th>
<th>Ed. (Years)</th>
<th>Dis.</th>
<th>M.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>76</td>
<td>Poor</td>
<td>Worse</td>
<td>Same</td>
<td>Dec.</td>
<td>Same</td>
<td>F</td>
<td>12</td>
<td>Yes</td>
<td>Wid.</td>
</tr>
<tr>
<td>2</td>
<td>67</td>
<td>Good</td>
<td>Worse</td>
<td>Same</td>
<td>Dec.</td>
<td>Same</td>
<td>F</td>
<td>17</td>
<td>Yes</td>
<td>Div.</td>
</tr>
<tr>
<td>4</td>
<td>68</td>
<td>Very Poor</td>
<td>Worse</td>
<td>Unk.</td>
<td>Same</td>
<td>Dec.</td>
<td>M</td>
<td>10</td>
<td>Yes</td>
<td>Wid.</td>
</tr>
<tr>
<td>6</td>
<td>78</td>
<td>Very Good</td>
<td>Same</td>
<td>Better</td>
<td>Dec.</td>
<td>Same</td>
<td>M</td>
<td>10</td>
<td>Yes</td>
<td>Mar.</td>
</tr>
<tr>
<td>7</td>
<td>69</td>
<td>Poor</td>
<td>Worse</td>
<td>Better</td>
<td>Dec.</td>
<td>Same</td>
<td>F</td>
<td>6</td>
<td>No</td>
<td>Wid.</td>
</tr>
<tr>
<td>9</td>
<td>61</td>
<td>Good</td>
<td>Worse</td>
<td>Same</td>
<td>Same</td>
<td>Dec.</td>
<td>F</td>
<td>13</td>
<td>Yes</td>
<td>Wid.</td>
</tr>
</tbody>
</table>
Table 8. Chi-square on Selected Common Factors and Extraneous Variables for Psychotherapeutic Drug Use

<table>
<thead>
<tr>
<th>Factor</th>
<th>Observed Frequency</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not married</td>
<td>6</td>
<td>4.3$a$</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Change in Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worse</td>
<td>7</td>
<td>4.5$a$</td>
</tr>
<tr>
<td>Better-Same</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Change in Activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased</td>
<td>8</td>
<td>3.6</td>
</tr>
<tr>
<td>Increased-Same</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>1.9</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

*aSignificant at .005; df = 1.*
Marital status did show a positive relationship to psychotherapeutic drug use. Thus, in this study, the unmarried person was more likely to take psychotherapeutic drugs on a regular basis than was the married individual. In addition, a person who stated that his health had changed for the worse was also more likely to use psychotherapeutic drugs on a regular basis than someone who felt his health was the same or better than it had been during the past five to ten years.

A weak relationship was noted between those individuals who reported a decrease in their activities over the past five to ten years and psychotherapeutic drug use. There are several interesting points apparent in Table 8. Seven of the ten individuals who took psychotherapeutic drugs regularly were females, and nine of the ten stated they had a disability. In this study, the mean age in years of people who took psychotherapeutic drugs on a regular basis was 70.2. The mean age for those who did not take these medicines regularly was 66.5 years.

Several important items were brought out by the subjects. Many of the participants who said that they had taken psychotherapeutic drugs on an infrequent basis had been first exposed to the drugs while hospitalized, some had only taken them during a hospitalization. Also, many of the individuals who stated their health had improved over
the past five to ten years attributed this improvement to some type of corrective surgery, such as a coronary artery bypass surgery.

**Findings Related to the Extraneous Variables**

A correlational matrix was constructed to see how the extraneous variables related to one another (see Table 9). There were several strong positive relationships at the .005 level of significance. A correlation between a change in health of a person and a change in his activity was noted \( r = .52 \). There was also a strong positive correlation between an individual's opinion of his present health and how he viewed his health as compared with others in his age group \( r = .53 \). The present health of an individual was positively correlated with the following two extraneous variables: a change in health and a change in activity. A strong relationship was also noted between an individual's opinion of his health as compared with others in his age group and a change in his activity.

When the extraneous variables were examined with the common factors, several strong negative correlations were apparent (see Table 10). These relationships were between disability and the way a subject viewed his health as compared with others in his age group and also between disability and a change in activity.
Table 9. Selected Correlation Among Extraneous Variables

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Present Health</td>
<td>1.0000</td>
<td>.4977&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.5285&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.2141</td>
<td>.4852&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.4195</td>
</tr>
<tr>
<td>Change in Health</td>
<td>.4977&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.0000</td>
<td>.4636&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.1984</td>
<td>.5235</td>
<td>.3163</td>
</tr>
<tr>
<td>Health Relative to Others</td>
<td>.5285&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.4636&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.0000</td>
<td>-.1373</td>
<td>.4906&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.1969</td>
</tr>
<tr>
<td>Attitude Toward Daily Activity</td>
<td>-.2141</td>
<td>-.1984</td>
<td>-.1373</td>
<td>1.0000</td>
<td>-.2685</td>
<td>.1280</td>
</tr>
<tr>
<td>Change in Activity</td>
<td>.4852&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.5235&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.4906&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.2685</td>
<td>1.0000</td>
<td>.4478</td>
</tr>
<tr>
<td>Change in Group Participation</td>
<td>.4195</td>
<td>.3163</td>
<td>.1969</td>
<td>.1280</td>
<td>.4478</td>
<td>1.0000</td>
</tr>
</tbody>
</table>

<sup>a</sup>Significant at .005.
Table 10. Selected Correlations Among Common Factors and Extraneous Variables

<table>
<thead>
<tr>
<th></th>
<th>Pres. Health</th>
<th>Chg. in Health</th>
<th>Health Rel. to Others</th>
<th>Chg. in Act.</th>
<th>Chg. in Gr. Par.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.1166</td>
<td>.3214</td>
<td>.2954</td>
<td>-.0274</td>
<td>.3219</td>
</tr>
<tr>
<td>Sex</td>
<td>-.0914</td>
<td>.0674</td>
<td>.0375</td>
<td>.1072</td>
<td>-.0504</td>
</tr>
<tr>
<td>M.S.</td>
<td>-.0140</td>
<td>-.3601</td>
<td>-.0613</td>
<td>-.1751</td>
<td>.0235</td>
</tr>
<tr>
<td>Ed.</td>
<td>-.2087</td>
<td>-.3642</td>
<td>-.3668</td>
<td>-.2304</td>
<td>-.2632</td>
</tr>
<tr>
<td>Dis.</td>
<td>-.3591</td>
<td>-.3401</td>
<td>-.5518&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.5458&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.2588</td>
</tr>
</tbody>
</table>

<sup>a</sup>Significant at .005.
There were several negative correlations which were weak between the common factors, education and disability, with several extraneous variables. These were between an individual's education and a change in health, and also between education and the health of an individual as compared to others in his age group. Two other weak negative correlations were between disability and a change in health over the past five to ten years and between disability and one's present health.
CHAPTER 5

DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

In this chapter, the findings as they relate to the conceptual framework and the review of the literature are discussed. The conclusions and recommendations for further study are also presented.

Relationship of Findings to Conceptual Framework and Review of Literature

This study was designed to determine if a relationship exists between social isolation and psychotherapeutic drug use in the adult. Five common factors were identified as having a possible relationship to both variables. The factors were age, sex, marital status, education, and disability.

An attempt was made to measure both social isolation and psychotherapeutic drug use. Thomas's (1970) scale to measure social involvement was used to determine social isolation. Psychotherapeutic drug use was determined by using a modified questionnaire by Manheimer et al. (1968).

It was assumed in this study that those people who were more socially isolated would take more psychotherapeutic drugs. A correlational coefficient could not be computed from the scores on social isolation. As a result,
the relationship of social isolation to other variables could not be determined. The data showed that those individuals who did use psychotherapeutic drugs on a regular basis had a lower mean score for social involvement than did those participants who did not take these drugs regularly.

Age plays an important part in social isolation and psychotherapeutic drug use. Weiss (1973) pointed out that the older adult, more than any other age group, loses significant relationships to death and other changing circumstances. Manheimer et al. (1968) found that the use of sedatives increased with age. In this study, the mean age in years of people taking psychotherapeutic drugs regularly was four years older than those subjects who did not take these medications on a regular basis. The psychotherapeutic drugs used regularly were either sedatives or tranquilizers. Only one person reported taking a stimulant, and that was used infrequently to keep awake while driving.

The sex of an individual is also important when social isolation and psychotherapeutic drug use is considered. Both men and women experience an increase in social isolation as they grow older. One reason given by Thomas (1970) is because retirement for men and widowhood for women occur more frequently in this age group. Both older men and women take a significant proportion of drugs, but there is a difference in their drug habits. Women, throughout all age groups, take more drugs than men (Rogers 1971).
In this study, 70 per cent of those who took psychotherapeutic drugs on a regular basis were female. The mean age in years of the females who took psychotherapeutic drugs on a regular basis was 68.5 while the mean age for males who took these drugs was 74.0 years.

It is recognized that marital status can influence social isolation. Levine (1969) stated that the death of a spouse may result in reduced social interactions. Webb and Collette (1975) reported that there was increased use of psychotherapeutic drugs in households where a person lived alone. In this study, of the ten people who said they took psychotherapeutic drugs on a regular basis, 60 per cent were not married. Forty-six per cent of the female respondents were married. This is in agreement with Hoffman (1970) who found that 46 per cent of females between the age of 65-74 are married. Ninety-seven per cent of the male participants were married. Hoffman (1970) reported that in his survey, 70 per cent of the men between the ages of 65-74 were married.

According to the literature, education does influence both psychotherapeutic drug use and social isolation. Johnson (1976) reported that her data showed an increase in social isolation scores as the number of years of school decreased. Parry (1968:803) stated that a pattern of higher psychotherapeutic drug use "did not prevail among the better educated..." This study seemed to
support the latter statement. The mean number of years of education for those who took psychotherapeutic drugs regularly was 11.4 and the mean number of years for those participants who did not take these drugs was 11.3.

It is felt that disability may result in social isolation by causing a reduction in one's social roles (Clark and Anderson 1967). The relationship of disability to psychotherapeutic drug use was not found in the literature. Pascarelli (1974) stated that disability causes increased stress in the older adult. In this study, 90 percent of the individuals who use psychotherapeutic drugs on a regular basis reported that they had some disability.

Conclusions

The conceptual framework stated that social isolation may influence psychotherapeutic drug use. Thomas's (1970) questionnaire on social involvement was used to measure social isolation. Those who took psychotherapeutic drugs regularly had a lower mean score for social involvement than did those who did not regularly take these drugs.

In this study, a greater percentage of females took psychotherapeutic drugs than did males, and a higher proportion of non-married individuals used these medications on a regular basis than did the married subjects. Also, those who took psychotherapeutic drugs on a regular basis
were four years older than those who did not take these drugs regularly.

A disability was present in 90 per cent of those who took psychotherapeutic drugs regularly. Strong negative correlations between disability and an individual's health as compared to others in his age group, along with changes in activity, were present in this study. Disability also showed a weak negative correlation to one's present health and to a change in health.

There were significant positive correlations between the following variables: one's present health and a person's health as compared with others, and also his present health with a change in activity. Positive relationships were also apparent between a change in health and the two variables, a change in activity and one's health as it compares with others.

Problems Encountered with This Study

There were several factors which may have influenced this study. A primary problem was the subjectivity of some of the questions. A number of older individuals responded that they felt their health was better than others in their age group by virtue of the fact that they had outlived many of their friends. The question on disability required a subjective response which might have influenced the data.
A number of subjects had difficulty answering the question: "How would you describe your present health?"

This study was conducted in a community in the southwest that attracts a significant number of retired people. Some respondents stated they participated less in group activities at this time because they are still becoming settled in this area.

The questions related to psychotherapeutic drug use required that an individual be aware of either the names of the medications he took or their use. Some subjects might not have been aware of this information and could not respond correctly to the question. Others may not have wished to admit taking a psychotherapeutic medication.

These patients were all ambulatory outpatients who were seeing a physician for a medical problem only. It was not determined by the investigator if they were being treated for any psychological problem by another doctor.

**Recommendations**

Based on the findings of this study, the following recommendations are made:

1. Repeat the study, using a larger sample; also, consider other factors which influence both psychotherapeutic drug use and social isolation such as income or chronic illnesses.
2. Design a better means to determine disability in an objective manner. This should include a scale which shows what the individual actually does, not what he is capable of doing, to see if this may influence social isolation.

3. Design a better means to help subjects determine what medications they take. A color chart of the psychotherapeutic drugs may facilitate this.

4. Control for other extraneous variables, such as possible psychotherapeutic drug use for psychological problems.

5. Repeat the study, using only individuals who take psychotherapeutic drugs on a regular basis.

Analysis of Data

All of the respondents seemed to be able to state if they were taking a psychotherapeutic drug. If the participant or his spouse were not able to give the specific names of the medications they were taking, they were able to state the purpose of each medication they were using.

The response to the question on disability was subjective, with the participant verbally telling the investigator the residual effects of each disability. In most instances, the researcher was able to observe the specific disability or its effects, such as emphysema. In other cases, disability was confirmed by the attending physician,
for example, the subjects with leukemia and multiple myeloma. Almost all of the respondents who had a disability stated that this had affected their particular lifestyle, including their activities.
CHAPTER 6

SUMMARY

This was a correlational descriptive study to determine if there is a relationship between social isolation and psychotherapeutic drug use in the adult. Five factors which had been identified in the literature as pertaining to both variables were studied. These were age, sex, marital status, education, and disability. It is felt that if a health care provider has increased understanding of these relationships, this information may help the older adult maintain his optimal degree of wellness.

There were 30 subjects, 15 females and 15 males, who met the criteria and participated in this study. Data were collected through a structured interview conducted by the researcher. Ten of the 30 subjects stated they took psychotherapeutic drugs on a regular basis, either daily or nearly every day. Because of the sample size, it was difficult to determine a strong relationship between social isolation and psychotherapeutic drug use. When the scores for social involvement were totaled, those individuals who took psychotherapeutic drugs on a regular basis had lower scores than those who did not use these drugs regularly.
The data from the ten individuals who took psychotherapeutic drugs regularly showed that these people were older than those subjects who did not take these drugs. Six or more of the ten individuals had the following characteristics: (1) they were female, (2) they were not married, (3) they stated their health had become worse over the past five to ten years, (4) they described their health as either poor or very poor, (5) they had experienced some decrease in their activity, and (6) they stated they had one or more disability.

The subjects who reported taking psychotherapeutic drugs said they took either tranquilizers, sedatives, or hypnotics. One individual stated he took a stimulant irregularly which was an over-the-counter medication and not prescribed by a physician.
APPENDIX A

CONSENT FROM THE HUMAN SUBJECTS COMMITTEE

Ms. Linda L. Bustamante
College of Nursing
Arizona Health Sciences Center

Dear Ms. Bustamante:

I have reviewed your proposal entitled, "Relationship of Social Isolation to Psychotherapeutic Drug Use in the Adult," which was submitted to the Human Subject Committee and concur in the opinion of the College Review Committee that this is a no risk project. Therefore, administrative approval is granted effective August 23, 1977, with the understanding that no changes in either the procedures followed or the consent form used (copies of which we have on file) will be made without the knowledge and approval of the Human Subjects Committee or the College Review Committee. Any physical or psychological harm to any subject must also be reported to each committee.

A university-wide policy requires that all signed consent forms be kept in a permanent file in the College Office to assure their accessibility in the event that university officials need the information and the principal investigator is no longer on the staff or unavailable for some other reason.

Sincerely yours,

/s/Milan Novak
Milan Novak, M.D. Ph.D.
Chairman
Human Subjects Committee

MN: pl

xc: Ada Sue Hinshaw, Ph.D.
Departmental Review Committee
APPENDIX B

SUBJECT'S CONSENT FORM

You are being asked to participate in a study which is looking at certain types of drugs (psychotherapeutics) taken by the adult person, and the possible reasons why these medications are ingested. The purpose of this study is to help nurses and other health professionals with their care of the adult. There will be no probably immediate benefit to those participating in this study, nor will there be any costs incurred by those individuals who take part in it.

This study will consist of an interview which will last about thirty minutes. This will be scheduled by the researcher at a time and place convenient for you. First, I will ask a few questions concerning your date of birth, education, marital status, and your health. Then, information will be asked about your participation in various functions, and your social interactions with family and friends. Finally, the types and amounts of certain medications (psychotherapeutics) you take will be asked.

You may withdraw from the study at any time. You are free to leave any question unanswered. This material will be confidential; a code number will be used instead of your name and only the principal investigator will have access to the identifying information. All data will be submitted for group analysis.

Your responses to the questions will not influence the care you receive by the physicians or any nursing personnel. Also, if you decide not to participate, or if you withdraw from the study, there will be no change in your care by either the physicians or any of their personnel.

Subject's Signature

Investigators's Signature

Date
APPENDIX C

PHYSICIAN'S CONSENT

I, ________________________________, have given Linda L. Bustamante permission to contact my patients to ask if they would participate in a study on the relationship of social isolation to psychotherapeutic drug use in the adult.

I understand that patient participation is limited to a structured interview in which questions of general information (age, sex, marital status, and education), social involvement, and psychotherapeutic drug use will be asked.

I am aware of the nature of the study. I have been told that all material is confidential and that only the principal investigator will have access to any identifying information. All data will be coded and submitted for group analysis.

I know that this study is being conducted under the direction of the Graduate Faculty, College of Nursing, The University of Arizona. Permission for this study has been obtained from the Human Subjects Committee, Arizona Medical Center.

Physician's Signature ________________________________

Date ________________________________
APPENDIX D

SOCIAL INVOLVEMENT SCALE

1. Would you mind telling me the date of your birth?
   Mo.   Day   Year

2. Concerning your health now, would you say it is very
good, good, poor, or very poor?

3. Would you say it has been the same during the past
five years?_________
   Has it been getting better, or has it been getting
good, poor, or very poor?

4. Do you think your health is better or worse than that
of other people your age?_________

5. Do you usually look forward to each day's activities?

Now I would like to know how you usually spend your time. I
am going to read a list of activities and ask you to tell me
which of these you do not and about how often you do them.

   At least   At least   Less   Often   Never
   once/wk.  once/mo.  Usually

1. Take walks
2. Tend garden or yard
3. Sit and think
4. Fish
5. Swim
6. Go on picnics,
   camping, boating
7. Go dancing
8. Go shopping
9. Go bowling
10. Drive a car
11. Take trips
12. Attend spectator
   sports
13. Attend plays,
   concerts, lectures

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14. Visit museums, art galleries
15. Attend church
16. Take classes
17. Visit or entertain friends
18. Watch television
19. Listen to radio
20. Sew, knit, crochet
21. Read
22. Work on hobby
23. Play cards or games
24. Go to library
25. Play golf or tennis
26. Play shuffleboard
27. Other activities
   List below
28. No activities

6. In general, would you say that your activities have remained about the same during the past five to ten years, or have they increased or decreased? ______

7. Are you a member of any of the following types of organizations or groups?

   Member | Attend | Contribute | Member of | Hold
   Church | Meetings | Financially | Committee | Office
   Health organization
   Neighborhood group
   Civic group
   Lodge or fraternal
   State society
   Recreational group
   Sr. citizens group
   Other

   ______
   ______
8. Do you find that this is more or less or about the same extent of participation as you had in such clubs and organizations five to ten years ago? ________________

9. In your opinion, are the people in this community friendly? _____________

10. Do you have any close friends or relatives in this community with whom you can talk over personal matters? ________________

11. Are these friends or relatives or do you mean you have both close friends and relatives here? ________________

12. Would you say you have more contacts with your relatives now than you did 10 years ago, or less, or about the same? ________________

Additional Information

1. What is your sex? __________

2. How many years of education have you had?
   - Grade school __________
   - High school __________
   - College __________
   - Post college __________

3. Do you have a disability? __________

4. If the answer is yes, what is your disability? __________

5. Marital status ________________
APPENDIX E

INTERVIEW GUIDE FOR QUESTIONS ON DRUG USE

1. Have you ever used any pills or medicines one or more times that help you stay awake, pep you up, help you lose weight, or cheer you up; pills that are often called stimulants, such as Dexamyl, Dexedrine, Elavil, Preludin, No-Doz, and the like?

2. Have you ever used any sedatives or sleeping pills, one or more times, such as Seconal, Phenobarbital, Doriden, Sleep-Eze, and the like?

3. Have you ever used any pills or medicines one or more times to help you calm down or keep you from getting nervous and upset; pills that are often called tranquilizers, such as Miltown, Equanil, Librium, Compoz, and the like?

For each affirmative answer to the above question, the subject will be asked:

4. Would you say you have used one fairly regularly, not regularly but fairly often, or just once or twice in your whole life?

5. When was the last time you used a pill or medicine like that—was it twelve months ago or less, between a year to three years ago, or over three years ago?
REFERENCES


