

# AN EXPLANATORY STUDY OF SOCIAL WITHDRAWAL EXPERIENCES OF ADULTS

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Social withdrawal may be a common problem among psychiatric patients and in persons who are experiencing stressful conditions in their social environment. As a psychiatric nurse the researcher identified this problem on in-patient wards and had little knowledge or skill to deal with it. It was also observed among staff members, especially the nurses themselves as they would frequently "withdraw" to the nursing station rather than attempt therapeutic communications with their patients. One could wonder if the specific nature of the nursing job had induced this withdrawal, or was it due to a reaction to the withdrawn patients? A similar state of affairs was again found when the researcher was a group counsellor in a provincial prison, and for more than five years she pondered about this perplexing situation.

While working as a research officer for one year, she finally was able to verify her perceptions of withdrawal by asking more than twenty psychiatric nurses if they felt withdrawn from their patients or if they noticed a pervasive amount of withdrawal behaviour in their patients. In order to obtain answers to these questions the phenomenon of withdrawal had to first be defined. Then many related questions fell into place, such as: What is the meaning and function of withdrawal for individuals? In other words, was withdrawal an active coping process or a self-defeating process for persons? What effect did withdrawal have in the lives of persons while they were engaged in it? Are withdrawn persons aware of their behaviour, and if so how do they name it or make meaning out of it?

Before these questions could be answered for the purpose of Ph.D. research, it became obvious to the researcher that it was first necessary to examine the nature of social withdrawal in order to better understand its function in the lives of adults. It was not only withdrawal behaviour but also the individual experiences of it that became the foci of interest in this study.

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As nurses begin to understand the varieties of social withdrawal experiences and their meanings and functions for patients, they may begin to identify withdrawn behaviour within a specific context and its effect on the persons involved. Nurses will then begin to understand their own reactions to withdrawn persons and also be able to identify their own withdrawal behaviour in the face of difficult patient problems (such as the grieving patient or the difficult "acting-out" patient). Social withdrawal may be a common human experience but so little is known about its basic components, including factors that affect it, both interpersonal and intrapersonal. So little is known about the process and functions of withdrawal in daily living. A clarification about the process of this phenomenon was seen to be helpful in directing nurses toward more appropriate interventions with patients during the various phases that occur during social withdrawal.

The purpose of this study was to understand the process of social withdrawal in the lives of a small number of adults. The researcher began with an assumption that social withdrawal can be a physical or psychological movement from other people and into self. The phenomenon called "social withdrawal" has been isolated as one variable whose dimensions have become clarified during this study including: the characteristics and types of withdrawal experiences, duration, context, outcomes, phases of changing perspective, and meanings and functions for the individuals concerned.

To date, social withdrawal has been examined in terms of behavioural variables with objective measurements during the past two decades in the fields of psychology, psychiatry, and sociology. There is a very confusing and complex set of terms that are applied to the conditions of social withdrawal and its manifestations in human behaviour often with conflicting meanings. In general, withdrawal behaviour has been identified as a part-process of many other related but very different phenomena such as depression, introversion, autism, schizophrenia, adolescent deviance, defense mechanisms, and reaction to stress and grief. The researcher concentrated primarily on the body of literature dealing with the existential experiences of persons in daily life, since this material pointed to withdrawal as an aspect of normal daily living (May, 1976; Moustakas, 1968, 1977; Sarton, 1973). This philosophical and social science literature presented an alternative meaning of withdrawal as being more than just a "maladaptive phenomenon." However, there was a paucity of literature about social withdrawal as an isolated phenomenon.

In the psychological and educational theory literature, social withdrawal was identified as a problem classroom behaviour of an increasing number of children and adolescents, with corresponding

symptoms of apathy, daydreaming, fatigue, and uncooperative behaviours (Appolloni & Cooke, 1977; Greenwood, Walker, & Haps, 1977). While some behaviour modification programs have been used in the attempt to prevent classroom withdrawal of children, there is little documentation about the experienced process of withdrawal in individual persons. In all of these studies, social withdrawal has been assumed to be a manifestation of anti-social and maladjusted persons that is caused by impoverished emotional nurturing and learning disabilities (Kanugo, 1979; Morris & Dolker, 1974; Susz & Marbeg, 1978).

Some studies have attempted to elicit individual perceptions of locus of control, powerlessness, and the degree of interpersonal distance needed for social comfort. For example, Duke and Mullens (1973) studied the "preferred interpersonal distance as a function of locus of control orientation in chronic schizophrenics, non-schizophrenic patients, and normals." They reported that the chronic schizophrenic patients perceived their locus of control external to themselves and they preferred to have more interpersonal distance than controls (non-schizophrenic patients). Preferred distance from interpersonal stimuli was greatest for schizophrenics and least for normals. Once again, the withdrawal perceptions and behaviours were attributed to abnormal reactions. Without the spontaneous descriptions of these persons' withdrawal experiences it is difficult to gain a full understanding of why, when, where and how withdrawal is experienced.

## RESEARCH METHOD

A beginning exploration about the process of social withdrawal required an inquiry method that is suitable for one-variable, inductive, and descriptive studies that attempt to build theory rather than to test theory that already exists. This method was appropriate because of the paucity of theory that was available about social withdrawal experiences. Also, the data would be primarily qualitative rather than purely quantitative, since the researcher did not intend to objectively measure the behaviours of withdrawal. The analytical process developed inductively, or with a movement from particular events to tentatively proposed generalities about those events. This type of analysis differed from the more common method of research which is hypothetical-deductive. Deduction is marked by a movement from general observations to particulars in a reductive way. Swanson and Chenitz (1982) claim that "The more we attempt to explain phenomena by reducing the data to their least common denominator, the further we are from what we experience in the world around us." However, the researcher is restricting the importance of their statement to studies that are exploratory and that deal with understanding

the *meaning* of behaviours. Theory testing is appropriate when the meaning of behaviours is first understood within specified contexts. The research approach employed in this doctoral dissertation may also be called phenomenological, although the researcher has specified her approach as being dialogical or that which is yielded by verbal interviews with study participants (Buber, 1970; Gendlin, 1962; Giorgi, Fischer, & Von Echartsberg, 1971).

According to Diers (1979), exploratory or descriptive studies answer the question related to "*What is this?*", and their main objectives are factor searching and factor isolating or naming. Also, this exploratory level of inquiry addresses the question "*What is happening here?*"; the study design is relation-searching and the kind of theory yielded is factor-relating (situation-depicting and situation-describing). On the other hand, hypothetical-deductive studies address the questions "*What will happen if . . . ?*" and "*How can I make . . . happen?*". The latter employ study designs of association-testing, causal hypothesis-testing, and prescription-testing, and they yield predictive and prescriptive theories. Depending on the type of question that is being addressed in the research, the study design would be selected in the above ways.

In this study about the process of social withdrawal in adults, the questions that were addressed (in application of the above model of research) included: "What is adult social withdrawal?" and "What happens during the adult experience of social withdrawal?" The research methods most suitable to answering these types of questions are interview questions that identify important factors about withdrawal, as well as the relationship between the factors that will then provide a process of related factors. Both the factors and the entire process of the withdrawal experience are named so that they can be more easily understood and communicated. The named factors are formed into the concepts or short descriptive words or phrases that serve to describe the commonalities of the participants' withdrawal process. In this way the factors are first isolated and then related.

#### a) *The Study Participants*

Only volunteers who were non-institutionalized adults were eligible for the study, since the researcher wanted to first understand the "normal" and everyday experience of social withdrawal without the confounding issues of institutionalization and current psychiatric treatment. The study was announced in three courses in a graduate department within the University of Toronto, and this resulted in getting 21 volunteers who were faculty members, graduate students, and friends of the students. Then eligibility criteria were established for selecting only 8 participants, as follows:

- (i) a voluntary interest in being interviewed about their episodes of social withdrawal that have occurred within the past three months,
- (ii) an identification of themselves as being socially withdrawn some time during the past three months,
- (iii) an ability to communicate fluently in the English language as well as a willingness to communicate personal experiences that would be held confidential and anonymous, and
- (iv) without being institutionalized for psychiatric disturbance or having received psychotherapy during the past three months and during the study period.

It is obvious that this purposive "sample" of participants has directly shaped the findings from this thesis. However, the purpose was not to gain a representative sample of adults' social withdrawal experiences, but an indepth understanding of some individuals' ongoing documentation about their periods of withdrawal.

From the group of 21 volunteers, only 8 were selected by the researcher as subjects for the study. The reasons for restricting the study to only 8 persons primarily reflected the need to manage the data that would be yielded from frequent and indepth interviews over a period of one year. From the pilot study, the researcher realized that the data would be copious and multi-variate even with a very small number of study subjects. Also, the desire to isolate and then relate factors about social withdrawal did not require a large number of persons since it would only complicate the study even more. A case study or case series approach to the data collection included a selection of a group of people who were the most different in age, occupation, and ethnicity from each other. The following information gives an overview of the subjects' characteristics:

Age: 25, 27, 28, 34, 36, 41, 43, 67  
 Sex: 4 males, 4 females  
 Education: 1 highschool level, 7 university level  
 Occupation: 1 unemployed, 1 artist, 1 retired army officer, 1 nurse, 1 counsellor, 1 professor, 1 minister/monk, 1 teacher.  
 Ethnicity: 1 Thai, 1 East Indian, 1 German, 5 Canadian

Although the data have been analyzed in the dissertation with very broad comparisons made between subjects for the above variables, this will not be examined in any detail in this report of the findings.



#### b) *Data Collection Technique*

A 3-month pilot study with 9 volunteers (6 of whom continued in the study proper) was completed to refine a verbal interview method with the most relevant questions about social withdrawal. The following material refers only to the study proper and not the pilot test period.

In the first interview each participant was asked to relax, reflect back in time, and with eyes closed (the latter was optional) so that each person could obtain a focus upon the features of their most recent (occurring within the past 3 months) withdrawal experience. A technique called "focusing" was used which required a mental visualization of the withdrawal image and a re-experiencing of the feelings and thoughts within the situation (Christensen, 1974). Once the person was able to focus upon a scientific withdrawal episode, the researcher then probed with questions pertaining to the following information:

1. The context of the withdrawal incident, including when and how it occurred and in response to what specific event.
2. A description of the particulars or events occurring within the process of the withdrawal experience, including duration of events.
3. The movement out of withdrawal, its context and outcomes.
4. An identification of their repeated withdrawal experiences from childhood to the present.
5. An abstraction of the overall meanings and functions of their withdrawal experiences, considering past and recent episodes.

A mean number of 8 interviews were conducted with each study participant, with a range of 16 meetings varying from 1 to 4-1/2 hours in duration for each meeting. The participants were never interviewed as a group but always individually. The informal dialogical approach to data collection continued until the researcher was clear about each person's withdrawal experiences. Interviews were arranged by the researcher and the individual differences in need and desire to talk about their withdrawal episodes varied with the person and with the number of withdrawal episodes that each person experienced during the study period.

#### c) *Data Analysis*

The researcher found a paucity of techniques for analyzing qualitative data that would preserve the descriptions of the study participants rather than reducing them to categories alone. Another difficulty was in the forms of the data. Several participants expressed images of their withdrawal experiences through drawing pictures,

writing diaries, poetry, and through physically portraying the experience to me with physical gestures and motions. Many of the experiences were indeed difficult for the participants to articulate and even to bring to conscious thought.

The analytical method is likened to factor analysis or content analysis whereby specific events are first identified in each participant's array of experiences, and then these are compared between participants in the attempt to ascertain the differences and similarities in these events or factors of experiences. For example, the researcher very quickly noticed that each participant had undergone a perspective transformation during their reactive withdrawal experiences to a specific crisis of events. This perspective transformation affected their previous points of view, and it was seen by the participants to be essential to their coming out of the withdrawal period (Mezirow, 1978).

Individual insights from the participants became highlights that formulated groups of concepts within the process of each person's withdrawal period. With the identification of the similar concepts of data (clustered events) followed the naming of phases within a pattern or process of withdrawal that was common to all participants. So, there was an analytical movement from the isolation of factors of events, to concepts, to named phases forming a process of withdrawal. Each named phase derived from the experiences of the participants, and the researcher was engaged in an interpretative account of the data.

#### *d) Reliability and Validity of the Findings*

The concepts of "credibility" and "auditability" have been proffered by Guba and Lincoln (1981) as substitutes for the specific terms "validity" and "reliability" for use when conducting an inquiry in social sciences that encompasses a qualitative or naturalistic mode of investigation.

##### Methods of credibility (validity):

(i) *Host verification* involved checking the accuracy of the raw data by sending a copy of each transcribed interview to a participant for verification prior to each subsequent interview and prior to the analysis of data. Also, data interpretations were first validated with each person prior to their final documentation in the form of the dissertation.

(ii) *Corroboration* consisted of monitoring all data for consistencies and inconsistencies that were yielded by each participant.

Methods of auditability (reliability):

(i) *Independent observer analysis* was completed by three dissertation committee members and one student who tested the correlation between sections of raw data with the interpretations in the analysis. This activity is also called "outside auditing," with a review of the data collection and analysis procedures to test appropriateness and good judgment. This separate judgment serves as an analogue to the principles of inter-rater reliability and replicability tests that are favoured by scientific inquirers.

(ii) *Phenomenon recognition* was ascertained by presenting the interpreted findings about social withdrawal to two non-participant groups (classes of graduate students, 38 total persons) and then asking them whether the findings not only made sense to them but if they represented their own experiences of withdrawal. Feedback forms indicated a 70% agreement with the study findings.

## FINDINGS

The total number of withdrawal episodes that were identified and discussed by all participants together had a range of 20 with a mean of 5 episodes occurring from childhood to present. This does not, however, represent the actual number of withdrawal episodes that occurred in these people's lifetimes, but only the episodes that could be recalled and which were perceived to be important to the participants.

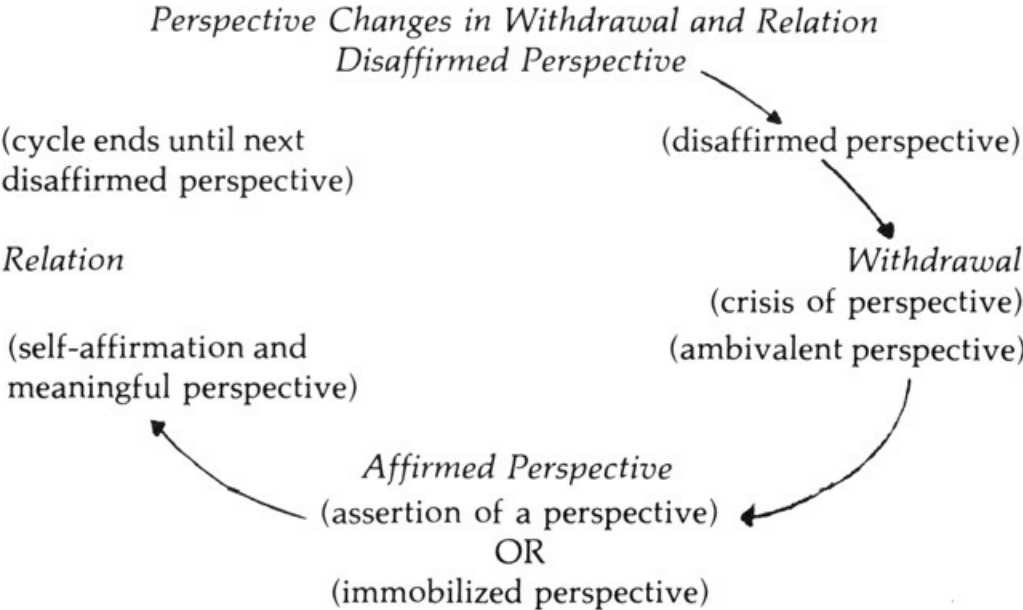
The data consisted of verbatim transcriptions of more than 2,400 pages of typed dialogue. Three types of social withdrawal experiences were identified from the data: active, passive, and reactive withdrawal. *Active withdrawal* was the least disruptive and most natural experience that was needed for contemplation, reflection, and thinking. Although only two participants reported this type of withdrawal experience, it is assumed that the other 8 participants also had this type of withdrawal but only focused on other types of withdrawal about which they were more aware and to which they attributed the meaning of "withdrawal." The type of withdrawal experience that was most reported by participants was probably dependent on what they conceptualized as a "withdrawal activity," and this varied from person to person. Active withdrawal is a very healthy and adaptive coping response to an overload of stimuli in the environment. Selective response to these stimuli includes brief moments of reflective withdrawal and periods of clarifying one's thoughts in preparation for action. *Reactive withdrawal* is probably a coping mechanism that is used as a defense against a stressful stimulus. It is precipitated by a disaffirming event such as an interpersonal conflict,



and this was the most common source of a disaffirming event for the 8 participants. *Passive withdrawal* is a more extreme form of reactive withdrawal, and in common with reactive withdrawal it is indicative of a maladaptive coping response to a stressful event. However, this withdrawal is a more prolonged period of immobilized inactivity that may become symptomatic of psychiatric or emotional disturbance (Cochrane, 1981).

Individual tendencies revealed that 2 persons had active withdrawal lasting from brief moments to several hours, 5 persons had reactive withdrawal that varied from a few hours to several weeks, and one had passive withdrawal for up to 3 months. These withdrawal tendencies were also consistent with their early childhood and adolescent withdrawal tendencies, which may point to a developmental sequence in the course of this phenomenon. It appeared that the majority of adult withdrawal experiences in this group were reactive in response to stressful events, and the stressful stimulus was almost always an interpersonal confrontation or conflict that sometimes resulted in a loss or separation from the relationship (for examples, marital/partnership termination, death of important person, job loss, confrontation from authority figure).

The following diagram illustrates the major movements that were identified in one withdrawal process. The events which name each movement in the circle portray the relationship between social withdrawal and social relationship, and they are perceived to be in a sequential relation to each other. This diagram may help the reader to understand the following set of events which marked five phases within the process of reactive withdrawal. It is *not* a common cycle to all three types of social withdrawal: active, reactive, and passive.



The process of reactive withdrawal was analyzed in detail because it was the most common type of withdrawal. The following summary depicts the phases within the process of reactive withdrawal.

### *Phase I: A Disaffirming Event*

This invoked the disaffirmation of a similar perspective; it is a disruption in one's previously held belief system and set of understandings about a particular person or event. One participant said: "Part of it was a loss of an important relation . . . All of a sudden his withdrawal was just snap! It was as if he just disappeared, left an empty space which I had to refill, and that was difficult to readjust to . . ." It is evident here that there is an interactive (social) effect of the withdrawal sequence such that the aversive stimulus may actually be withdrawal behaviour from a significant other person. More than three persons used the word "disruptive" and "overwhelming" to describe the disaffirming event. The researcher interpreted that there was an unexpected change in their external experience, and this change was marked by a disaffirming event to their personal identity and to their lifestyle perspective.

### *Phase II: A Crisis of Perspective*

This phase included disorientation, confusion, perfuse anxiety, lack of control (internal), painful emotions, overload of thoughts and feelings, and depression, which is represented in the following data from six different participants:

"I don't know what's happening to me."

"I'm shaking and I feel like being sick."

"I am so tied up with negative emotions that I cannot move."

"I had depression . . . I wanted to rip feelings out of me."

"I was overtaken by emotions . . . My heart was aching."

"I scattered, went crazy. Confused. No meanings. Began to withdraw to myself." "I had no control over it."

Fear often resulted from this lack of awareness of what was occurring or could occur to the person during the crisis. Some participants doubted their level of integrity and sanity when they were in this phase. A sense of powerlessness was embraced in the references to statements such as: "It's a horrible realization that I can't take care of myself right now." Some participants felt "immobilized" by their emotions, and one person said she was "saran-wrapped and tied up with pain." The clinical significance of this phase of the withdrawal is that it is easy to observe temporary manifestations of mental disturbance that may soon pass. The danger would be to label the symptoms of this phase of withdrawal without understanding the full process of the withdrawal as a coping response to a distressing life situation. This

Contrary to the above experience, one person attempted suicide during his withdrawal and he was hospitalized on a psychiatric unit so that he could receive assistance to end his withdrawal experience. phase lasted from a few minutes to 2 to 3 weeks in six of the study participants. The persons who had a tendency toward active withdrawal did not experience any of the above, and they felt very much in control of their internal wellbeing and external environment. Lefcourt's (1976) theories of internal-external locus of control were helpful for the understanding of this phase.

### *Phase III: An Ambivalent Perspective*

Competing perspectives and emotional vacillation were common in this phase of reactive withdrawal. It may represent a process of disintegrating old perspectives and integrating new perspectives at the same time, with a resulting "heightened perspective," as one participant called it. It is a "confrontation with self" and a time of "pulling apart the pieces and parts" of the dilemma. "I had a divergence of ideas and impulses" one person said, and this was part of what she called a "centring process" that eventually got her in touch with her innermost values, goals, and priorities. All participants said that it was also a time of reflective thinking when the competing issues had to be worked out and clarified. The ambivalence of competing and sometimes conflicting alternatives provides the time of "holding back" prior to taking a course of action. This is actually the stage of conflict resolution in the problem-solving process of coping, and all six participants who experienced reactive withdrawal identified a conflict that they needed to work out during this phase (Spivack, Platt, & Shure, 1976).

### *Phase IV: The Assertion of a Perspective OR Immobilized Perspective*

This phase was appropriately named by one person as an "existential turning point," and by another person as a "moment of decision," since it represents the juncture of two possibilities: the assertion of a "heightened perspective" or becoming "stuck," "depressed," and "inert." This is the phase of acting upon a decision by asserting a new behaviour or attitude, or reclining still further into withdrawal, but this time to a passive withdrawal experience. The perspective shift can be seen in one participant's description: "I was getting older and realizing that I could make things happen to a certain degree, but I had to let go of the past, let go of an old image of myself." One person called it a phase of "breaking through barriers." Verbal expressions is an important part of this phase, which is evident in the following statement: "Finding words to describe and interpret my experience is part of regaining control and power. Remaining inarticulate drives me crazy."

Clinical depression became apparent at this point in the withdrawal, and the participant appeared to be self-preoccupied with his troubles. He said that he was in a continued state of "confusion and anxiety." He felt "helpless" and "unable to cope." Worse still, he felt "alienated from everything around," and "resigned" to his circumstances.

It is feasible that if the withdrawal episode is not terminated during this phase there may be deeper and more prolonged periods of indecision that represent an inability to cope or to solve the problem. Two persons claimed that they required the assistance of other people to help them to end their withdrawal episode and to regain an internal "sense of control over what was happening in the withdrawal."

#### *Phase V: The Self-Affirmation and Meaningful Perspective*

One person summed up the outcome of this phase for her: "The process of meaning-making is the process to regain personal power . . . I am driven towards the gestalt." This phase is marked by a feeling of comfort and ease in social relationships; in short, the conflict is resolved and there is a sense of gestalt or completion. The "insights came" for one person, and for another there was personal "acknowledgement" by an important person. It was after they had ended their withdrawal (wilfully) that all participants were able to recall the details and make sense from the specific events and phases of their withdrawal experiences. It seems that during the withdrawal itself there is difficulty in being aware of what is actually happening. Following the withdrawal process there can be the creation of meaning about the crisis and the response to the crisis. It is important to note that the two participants' experiences of active or rhythmic withdrawal were not at all painful but were perceived to be in harmony with their environment and with their personal development. It is proposed that a deeper process of withdrawal occurs following a personal disaffirmation, and a still deeper and potentially harmful process of withdrawal occurs in a passive and debilitating state where the duration of the withdrawal is much longer (up to several months).

It is likely that the majority of the participants had reactive withdrawal and the minority of them had a tendency to have active withdrawal because this was a highly selected group of people who had originally identified themselves as being "withdrawn" during the three month period prior to the study. This is perhaps not a "representative" sample of people in that respect, although one may hypothesize that reactive withdrawal is the more common type of experience in the face of crisis for many other individuals.



## IMPLICATIONS FOR NURSING PRACTICE

It is vitally important for nurses to be able to understand withdrawal behaviour and withdrawal experience of all patients, since withdrawal may be a "natural" response to the stress of illness. These findings are not only relevant for psychiatric nurses who may witness the manifestations of withdrawal as a basic and underlying function in most clinically disturbed individuals, but also for persons in distress. Withdrawal behaviour may be understood within the context of a stimulus-response paradigm where it is a coping response to an aversive stimulus in the patient's immediate environment. Even a lack of privacy, which is so often experienced during hospitalization, may provide the aversive stimulus to provoke a process of withdrawal within a patient. More importantly, though, it is usually in response to a significant disruption in one's life and often with a resulting interpersonal loss that withdrawal is activated. The withdrawal process may be similar to crisis resolution.

The identification of withdrawal behaviour should always be validated with the patient's experience, since there may sometimes be poor concurrent validity between behaviour and experience. When a withdrawal experience has been confirmed with the patient it is then important to carefully assess the context or stimulus for the withdrawal. The withdrawn individual may be able to verbalize what is happening and, indeed, the verbalization and contact with another person is therapeutic in itself. Once the problem is identified it is important to help the patient work through the phases of problem-solving, which include the generation of options and alternative behaviours (Spivack et al., 1976), and good decision-making that is appropriate to the problem stimulus. An understanding of the patients' perceived obstacles toward the goal must be realized in order to coach a patient through this phase of self-doubt and ambivalent thinking. Communication with the patient is probably the most effective way of intervening with a withdrawal episode, but it is imperative that nurses become sensitive to times when it is appropriate to let the patient endure some silence so that a natural thinking process can be issued. The helper stance precludes a forced set of opinions onto the patient, which in the end only complicates the patient's own problem-solving process (because there is yet another aversive stimulus to deal with concomitant to the existing problem).

Last of all, it is imperative that nurses be able to identify the differences between a self-inhibiting and potentially destructive withdrawal experience from a self-enhancing and potentially healthy coping process in each individual. This is sometimes difficult to assess, since the experience of withdrawal may be operationalized in a variety



of ways among patients. The existing body of knowledge about withdrawal experience and behavioural expression is inadequate, and it is difficult to find an objective "measure" of this phenomenon. The nurse can, however, closely monitor the patient's withdrawal behaviour but always with notes about the patient's own context and perceptions of the experience. The withdrawal experience can be classified according to the analysis that is proffered in this thesis, according to active, reactive, and passive withdrawal, with evidence of the patient's interpersonal and intrapersonal experiences to support the choice of classification. With passive withdrawal there is very little interpersonal contact initiated by the patient towards another person. Instead, there is more intrapersonal preoccupation and lack of physical activity, and clinical symptoms of depression may become apparent. It is important, however, not to confuse withdrawal with depressive behaviour because it is hypothesized that they are two different phenomena. This hypothesis remains to be tested in a currently conducted analytic survey of the coping responses of parasuicide patients who are undergoing extreme stress.

## CONCLUSION

Theory building research is best followed up by theory testing research, since the findings from this explanatory inquiry are highly inferential and tentative. One of the difficulties of descriptive research of this kind is that precise measures of prediction, replicability, *external* validity, and reliability of the findings are as yet unknown. The findings must be tested in a more rigorous and systematic fashion through hypothetical-deduction and through randomized controlled trials. The researcher is currently testing the findings yielded from her dissertation by conducting an analytical survey of coping patterns in a random sample of persons, and then a randomized controlled trial will test the effects of a coping skills program with an experimental and control group of parasuicide patients.

A process of reactive withdrawal has been described, and some of the social contexts and outcomes of withdrawal experiences have become clarified. Very little has been proffered about the behavioural dimensions of withdrawal, and further research is needed to develop this area.

In his book called *How Adults Learn*, Roby Kidd (1973) unveiled an essential meaning of the learning process, which he called "being, becoming, and belonging." He purported that researchers and practitioners have tarried too long upon the surfaces of human encounters of daily living to the sad neglect of understanding the experiences of being human. We need to expand upon our understandings about

common human phenomena, particularly those phenomena that relate to the human effort to cope with adverse circumstances in daily living. The cultural variations of social withdrawal would contribute to our knowledge of the social contexts and acculturation processes that are other factors which may direct the course of withdrawal experience.

Last of all, the distinctions between social withdrawal and the grieving process must be carefully examined in future work, along with the distinctions between depression and schizophrenia with social withdrawal. More sensitive assessment tools may enable us to clearly identify and classify the differences in these clinical features. In addition, social withdrawal must not be restricted in meaning as a clinical symptom; it could be viewed in the light of human adaptive processes that may assist individuals to achieve a very potent coping response and learning event. On the other hand, withdrawal may become a very self-inhibiting coping response that is ineffective for some persons. These distinctions must be further clarified through continued research about social withdrawal.

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## RÉSUMÉ

### Étude exploratoire des expériences de recul social chez les adultes

Le recul social peut se manifester fréquemment chez les patients psychiatriques et également chez les personnes qui vivent des expériences de stress dans leur milieu. La présente étude vise à comprendre, au moyen de l'analyse de cas, le processus de recul social vécu par huit adultes. L'étude part de l'hypothèse que le recul social peut être un mouvement psychologique ou physique, un retrait face aux autres, et en soi-même. Les données recueillies ont permis d'identifier trois types de recul social: le recul actif, le recul passif et le recul réactif. L'analyse de contenu a révélé un processus commun de retrait chez six participants, processus qui comprenait les étapes suivantes: négation de la perspective, crise de perspective, perspective ambivalente, assertion d'une perspective et affirmation de soi. Ces cinq étapes n'étaient communes qu'au processus de recul réactif et l'analyse des résultats a porté principalement sur un examen détaillé de ce processus. Cela signifierait que le recul réactif pourrait être une réaction qui permettrait de faire face au stimulus aversif du milieu social, mais il peut être relié à un trouble émotif s'il se prolonge ou devient passif.