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# The Relationship Between Meaning in Life & the Occurrence of Drug Abuse: An Epidemiological Retrospective Study

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Thomas

1992



THE RELATIONSHIP BETWEEN MEANING IN LIFE  
AND THE OCCURRENCE OF DRUG ABUSE:  
AN EPIDEMIOLOGICAL RETROSPECTIVE STUDY

A Thesis

Presented to

the Faculty of the Department of Educational Leadership  
Western Kentucky University  
Bowling Green, Kentucky

In Partial Fulfillment  
of the Requirements for the Degree  
Masters of Arts  
in Education

by

Thomas Nicholson

December, 1992

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THE RELATIONSHIP BETWEEN MEANING IN LIFE  
AND THE OCCURRENCE OF DRUG ABUSE:  
AN EPIDEMIOLOGICAL RETROSPECTIVE STUDY

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## TABLE OF CONTENTS

Chapter	Page
1. INTRODUCTION . . . . .	1
Purpose of the Study. . . . .	5
Need for the Study. . . . .	5
Hypotheses. . . . .	7
Delimitations . . . . .	7
Limitations . . . . .	7
Assumptions . . . . .	8
Definitions . . . . .	8
2. REVIEW OF LITERATURE . . . . .	10
Risk Factors for the Development of Drug Abuse. . . . .	11
Theories on Drug Abuse. . . . .	14
An Overview of the Existential Perspective. . . . .	24
3. METHODS. . . . .	30
Hypotheses. . . . .	30
Population. . . . .	30
Sample Selection . . . . .	30
Design. . . . .	31
Instrumentation . . . . .	32
Data Analysis . . . . .	36
4. RESULTS. . . . .	38
Description of Study Sample . . . . .	38
Descriptive Data. . . . .	39
Tests of Hypotheses . . . . .	39
5. CONCLUSIONS. . . . .	44
Summary of Results. . . . .	44
Discussion. . . . .	45
Limitations . . . . .	47
Conclusions . . . . .	48
Implications. . . . .	52
Recommendations . . . . .	52
REFERENCES . . . . .	54
APPENDICES	
A. Intake Data Form. . . . .	62
B. Short Michigan Alcohol Screening Test . . . . .	63
C. Purpose in Life Test. . . . .	64
D. Life Attitude Profile-Revised . . . . .	67



LIST OF TABLES

	Table	Page
1.	Descriptive Statistics on the Purpose In Life test . . . . .	40
2.	Descriptive and Inferential Statistics on the Life Attitude Profile--Revised (n=49 for all values) . . . . .	42

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Humans have been using plant-derived drugs for as long as we have recorded history. Significant negative drug abuse related consequences occur in the areas of health, social issues, family relations, legal systems, and economic productivity. The purpose of this study was to assess the relationship between meaning in life and drug abuse. An epidemiological, retrospective study was performed to compare personal meaning in life between 49 individuals receiving in-patient treatment for drug abuse and a group of 49 matched, non-drug abusing controls. Study participants completed the Purpose-In-Life Test and Life Attitude Profile-Revised. On both instruments, the in-patient drug abusing subjects were found to have significantly different levels of meaning in life. Drug treatment and primary prevention programs should consider some attention toward life meaning issues in their strategies or environments. Future research should explore in greater detail and with larger samples drug abusers' subjective assessment of life's meaning.



## Chapter 1

### INTRODUCTION

Drug use is not new. Humans have been using plant-derived drugs for as long as we have recorded history--as far as we know, since Homo sapiens first appeared on this planet. A Neanderthal burial site in Iran, approximately 60,000 years old, contains flowers which are still recognized as folk medicines. By the time farming came into practice 10,000 years ago, all major human population groups were probably using drugs. Our earliest samples of recorded history contain references to the regulation and distribution of mead, beer, and wine (Rucker & Rucker, 1989). Ancient Egyptian mothers would feed colicky babies a mixture which included opium to help them sleep (Scott, 1969). The Chinese emperor Shen Nung (2737 BC) recommended cannabis for a number of ailments including gout and malaria (Snyder, 1970). In the book of Genesis, the hallucinogenic mandrake root is mentioned in association with sexual activity (Genesis 30:14-16).

American history is also replete with the production and usage of psychoactive drugs. Tobacco was a major crop in early America used for both medicinal and recreational purposes (Heimann, 1960; Stewart, 1967). In the late 1800's cocaine was a common ingredient in medicines and cola drinks (Musto, 1989). Indeed, America's independence movement had connections to the sale of drugs. The "Boston Tea

Party" with its attendant cry "No Taxation Without Representation" helped trigger the American revolution.

It is apparent that drug consumption is part of human history. An assortment of drugs have been consumed for a variety of reasons (i.e., recreational, therapeutic, and religious) over thousands of years. These drugs have been used with no or minimal ill effects and abused with tragic human consequences.

Currently most, if not all, Americans consume psychoactive drugs (Duncan & Gold, 1982). Legal products such as alcohol, tobacco, coffee, tea, chocolate, and certain prescription psychoactive drugs are widely consumed. Less widely used are the predominantly illegal drugs such as heroin, cocaine, and marijuana. All of these drugs, legal and illegal alike, have potent central nervous system effects, and if abused, can produce deleterious effects upon the human body. The legal status of these drugs (licit or illicit) thus is not based on their pharmacological effects nor on their potential for harm. For example, in the United States in 1988 the illegal drug cocaine was directly responsible for about 1600 deaths while the legal drug tobacco killed 390,000 people (Department of Health and Human Services [DHHS], 1989).

Drug consumption can be categorized into the areas of drug use and drug abuse. Drug use is taking a drug in such a manner that the sought for effects are



attained with minimal hazard (Irwin, 1973). If John Doe (an adult) consumes a glass of wine with his Sunday dinner, this is an example of drug use. During the 19th century, Pope Leo XIII praised the "use" of vin Mariani (i.e., a red wine laced with cocaine) as a boon to humanity because it made fasting easier on holy days and as penances (Duncan & Gold, 1982). Drug abuse is taking a drug to such an extent that it greatly increases the danger or impairs the ability of the individual to adequately function or cope with his/her circumstances (Irwin, 1973). If John Doe drinks a gallon of wine at every dinner, this would be drug abuse.

Significant negative drug abuse related consequences occur in the areas of health, social issues, family relations, legal systems, and economic productivity (American Public Health Association, 1989). Approximately 50 million Americans (26% of the adult population) regularly smoke tobacco and 90% of these smokers are physically addicted to nicotine (DHHS, 1988). Between 1964 and 1983 the direct cigarette induced medical costs were an estimated \$930 billion (National Interagency Council on Smoking and Health, 1984). Of the over 100 million American adults who consume alcohol (67% of the adult population) an estimated 8 to 15 million or roughly 10% are either alcoholics or problem/heavy drinkers (Carroll, 1989;

DHHS, 1987). Alcoholism and alcohol abuse costs the U.S. an estimated \$117 billion a year. Of this amount, \$13 billion is spent on treatment alone (Lord, 1987).

Accurate statistics on illicit drug consumption are harder to ascertain. For adults over the age of 26, 27% claimed to have tried marijuana, 10% tried cocaine, 8% tried stimulants, 6% tried hallucinogens and 1% had tried heroin (National Institute on Drug Abuse, 1985). There are an estimated 400,000 to 500,000 heroin addicts in the United States (Ray & Ksir, 1990). Of regular users of other illicit drugs, an estimated 10-15% are physically and/or psychologically dependent on them. Approximately, \$10 billion a year is spent by law enforcement agencies attempting to control the illicit drug trade. Cocaine is now the most profitable article of trade in the world and a \$100 billion a year business in the U.S. ("It Doesn't Have," 1989).

It is readily apparent that issues related to drug consumption and distribution permeate American society. Significant negative consequences from drug consumption are felt in the areas of public health, law enforcement, family relations, and economic productivity. This study will focus on a possible contributing factor to one of these problems, namely, individual abuse of drugs.



### Purpose of the Study

The purpose of this study was to assess the relationship between meaning in life and drug abuse. Specifically, does an absence of self-perceived meaning in life contribute to the development of drug abuse? An epidemiological, retrospective study was performed to compare personal meaning in life between individuals receiving in-patient treatment for drug abuse and a group of matched, non-drug abusing controls.

### Need for the Study

Given the tremendous burden of drug abuse upon society substantial efforts are being made to reduce the deleterious outcomes of this abuse. Primary prevention programs such as drug education in schools are aimed at preventing the onset of drug abuse. Secondary prevention programs (i.e., the early detection and prompt treatment of problems or disorders) such as screening and employee assistance programs aimed at detecting abusers and channeling them into treatment are now commonplace in work settings. Also, tertiary prevention programs that attempt to keep drug abuse from having long-term effects on the individual or society have received increasing attention in recent years. In-patient drug/alcohol treatment programs are examples of these approaches.

To date, knowledge of the causes of the various forms of drug abuse remains incomplete. It appears

that a multifactorial system of causation best explains the occurrence of drug abusive behavior. Some combination of biological, psychological, emotional, and sociological factors increase certain peoples' probabilities of abusing psychoactive drugs. This incomplete knowledge base in understanding the 'Web of Causation' of drug abuse is manifestly evident when looking at drug treatment. Current treatment programs are partially effective at best. The most effective drug (i.e., alcohol, heroin, tobacco, and polydrug abuse) treatment programs have long-term success rates of between 20 to 30 percent (Clifford, 1991; Ray & Ksir, 1990).

An increase in understanding of the origins of drug abusive behavior in individuals could substantially improve the effectiveness of primary, secondary, and tertiary drug abuse prevention programs. Frankl (1959) has hypothesized that a sense of meaninglessness or purposelessness about one's life may contribute to the development of drug abuse. Considering the magnitude of America's current drug problems and the low rates of success for drug treatment programs, the exploration of meaning in life and its relation to drug consumption is warranted.



### Hypotheses

The following hypotheses were tested:

1. There will be no significant difference in meaning in life as measured by the Life Attitude Profile - Revised between drug abusers and matched controls.
2. There will be no significant difference in meaning in life as measured by the Purpose in Life test between drug abusers and matched controls.

### Delimitations

This study was delimited to in-patient residents at the Buffalo Valley and Tennessee Christian Treatment Centers between June 1, 1991 and June 30, 1991.

### Limitations

This study had the following limitations:

1. Caution should be exercised when generalizing results to the drug abusing population in the United States, since study subjects may not be representative of all drug abusers.
2. Individuals who were tested during the last four days of their treatment program were dropped from the analysis. This phase of treatment is typically marked by a very high level of euphoria which is transitional in nature. The deletion of these subjects will limit the ability to generalize the findings of this study to the entire patient population of these facilities.

3. This study will assess meaning in life among a sample of drug abusers after they have developed a drug problem. There will be no way to ascertain, in this particular study, whether the levels of meaning found also existed within these patients before they developed their drug problem. As such, if any differences are found between the drug abusers and the non-drug abusing controls, it will be impossible to determine if this was a cause of drug abuse or a consequence of it.

#### Assumptions

The following assumptions were made in this study:

1. It is assumed that subjects in the study will complete the questionnaires honestly and to the best of their ability.

2. It is assumed that subjects in the study will understand how to complete the questionnaires properly and will do so.

3. It is assumed that the nondrug abusing control subjects do not abuse drugs.

#### Definitions

The following are definitions of terms used throughout this thesis:

1. Drug - Any substance that, by virtue of its chemical nature, alters the structure or functioning of any of the tissues of a living organism (Gold & Duncan, 1982).



2. Drug Abuse - Taking a drug to the degree that it greatly increases the hazard or impairs the ability of an individual to adequately function or cope with their environment (Irwin, 1973).

3. Psychoactive Drugs - Drugs that alter consciousness and thought processes. They alter an individual's thoughts, feelings, and/or behavior.

## Chapter 2

### Review of Literature

The consumption of drugs has been pervasive throughout human history. The reasons behind human psychoactive drug consumption are both numerous and multifaceted. Schlaadt and Shannon (1990) state:

The reasons individuals use psychoactive substances vary as much as the individuals themselves: to find sexual fulfillment, to seek spiritual enlightenment, to have fun, to produce mood fluctuations, to enhance athletic performance, to reduce inhibitions in bar settings, to fight boredom, to satisfy curiosity, to be "in" as opposed to "left out". (p. 16)

Ray and Ksir (1990) state that people consume drugs to either reduce the pain or increase the pleasure in their lives.

Recently, attempts have been made to isolate specific factors that tend to increase or decrease drug consumption. The reasons presented for drug use are very similar to those which lead toward drug abuse but not identical. In recent years there has also been an emerging consensus among drug researchers on the etiology of drug abuse. It is apparent that no one model totally accounts for either the development of drug abuse or provides a framework for an effective treatment modality. This has led scientists to argue a



multicausal etiology for drug abuse (i.e., Web of Causation). Within this model each of the major schools of thought have something to offer and most of the individual models to be reviewed in this chapter are not mutually exclusive. That is, if one is correct, the others are not necessarily all wrong. The web of causation of drug abuse consists of numerous component theories, each possibly contributing to the total variance of abusive behavior.

#### Risk Factors For The Development of Drug Abuse

Specific factors often cited as predisposers to drug use include recreation and social facilitation, sensation seeking, spiritual/religious factors, curiosity, altered state motivations, rebellion and alienation, personality traits, peer pressure, social environment, economic conditions, genetic endowment, family/parental influence, demographics (i.e., age, gender, etc.), and stress management (Carroll, 1989; Schlaadt & Shannon, 1990; White, 1991). The question remains, however, as to what factors separate the majority of humans who use drugs safely or with minimal negative consequences from the minority that may be predisposed to develop abusive drug behavior.

One clear pattern which exists is that drug abusive behavior most often starts in adolescence (White, 1991). During this development period children experience hormonal and growth changes, strong peer

influences, identity formation, and differentiation from one's parents (Fields, 1992). Brook, Whitman, Gordon, and Cohen (1986) in a longitudinal study identified personality traits that, if carried into adolescence increased the potential for drug abuse. These characteristics included (a) nonachievement--a lack of motivation, (b) interpersonal relations--aggressive behavior, (c) intrapsychic functioning--depression, (d) uncontrolled emotions--impulsiveness, and (e) unconventionality--a need or tendency to rebel. Labourve and McGee (1986) found adolescents who consumed drugs heavily scored much higher on tests measuring impulsiveness, exhibitionism, autonomy, affiliation, and play and lower on tests measuring achievement, cognitive structuring, and harm avoidance. Other adolescent characteristics associated with drug abusive behavior include having problems with school authorities, poor academic performance, frequent school absences, and greater involvement in petty crime (Kandel, 1974; Zucker & Gomberg, 1986).

It is also apparent that a person without any drug problems by their mid-twenties is not likely to develop them. The major exception to this pattern of adolescent onset is with alcohol. While heavy drinking may begin in adolescence, the development of full blown alcoholism usually occurs later in life (Vaillant, 1983).



A second frequently stated risk factor for drug abuse is poor self-concept within the individual. Fields (1992) defines self-concept as having a 'sense of self'. An individual with good self-concept feels like they are a unique and worthwhile individual, capable of accomplishing life tasks and trusted by and can trust others. It is argued that individuals who possess the aforementioned characteristics are at least partially inoculated against developing drug abuse problems.

A third risk factor for drug abuse, as noted earlier, is poor school performance. Drug abuse is highly correlated with academic failure, especially in the late elementary grades (Kandel, Kessler & Margulies, 1978; Rubins, 1978).

Exposure to drugs is another requisite for developing drug abusive behavior. For most individuals this would involve peer or familial exposure or both. It is well documented that peer groups exert tremendous influence on individuals, especially in adolescence (Schlaadt & Shannon, 1990). For many individuals drug consumption is required to enter and stay in specific social groups. The most influential group which may influence drug taking behaviors is the family. Parents, older siblings and other relatives can provide either positive or negative role models in relation to drug taking behavior. Overall, children raised in drug

abusing or dysfunctional families are at greater risk for developing drug problems themselves (Fields, 1992; Schlaadt & Shannon, 1990; White, 1991).

The presence of any of the aforementioned risk factors within individuals increases the probability that they will develop drug problems. Many people possess one or more of these factors; however, they don't develop drug problems.

#### Theories on Drug Abuse

Prior to this century drug abuse was not seen as a health or medical problem. Individuals with drug problems were seen as deficient in character, self-control, will power or moral fiber. As such, these individuals were more often handled by religious personnel such as priests (McKim, 1991).

Today theories on drug abuse fall into three broad categories (a) biological, (b) psychological, and (c) sociocultural. As noted earlier, these categories are not mutually exclusive and each offers unique insights into drug abusive behavior.

#### Biological Theories

Many professionals view drug abuse as a disease with probable genetic and physiological components. The American Medical Association in 1957 stated alcoholism was a disease based on the following three factors (a) a known etiology, (b) progression of symptoms which get worse over time, and (c) a known



outcome (Fields, 1992). Jellinek (1960) proposed that the alcoholic was unable to consistently predict in advance how much they would drink, at any specific time with the expression of abusive drinking varying among people. Specifically, alcoholism fell into the following categories (a) Alpha--psychologically dependent on alcohol but could at times abstain, (b) Gamma--physical dependence and progressive loss of control over drinking, (c) Beta--not psychologically or physically dependent on alcohol but demonstrated medical symptoms of chronic alcohol abuse (i.e., cirrhosis, gastritis, etc.), (d) Delta--physical dependence on alcohol but few/no physical problems from chronic drinking, and (e) Epsilon--binge drinking.

Genetic and epidemiological studies have provided support for the medical model by demonstrating physiological components to both alcoholism and nicotine addiction (Collins & deFiebre, 1990). Goodwin (1971) studying adoptions in Denmark found that sons of alcoholics were four times more likely to become alcoholics than sons of nonalcoholics. Cloninger, Bohman, and Sigvardsson (1981) confirmed Goodwin's research and found that (a) sons of biological alcoholic parents are classified as alcoholics at earlier ages than their peers, (b) adopted sons of alcoholic biological parents are four times more likely to develop alcoholism than adoptive sons whose

biological parents were not alcoholics, and (c) daughters of alcoholic fathers do not have higher evidence of alcoholism but do demonstrate a higher evidence of frequent physical complaints and somatic anxiety.

Studies of identical and fraternal twins have also supported a genetic component to alcoholism (Huber & Omenn, 1981; Kaij, 1960). And Blum, Noble, Sheridan, Montgomery, Ritchie, Jagadeeswaran, Nogami, Briggs, and Cohn (1990) identified a link between the receptor gene for the neurotransmitter dopamine and alcoholism. It is apparent however, that any such genetic trait does not follow a simple Mendelian pattern. The relationship between genotype and environment can be defined as follows:  $G + E + (G \times E) = 1$ . Therefore, genetic factor (G) and environmental factors (E) influence the magnitude of any given trait plus any genetic environmental interactions. In actuality, then, the genotype sets a template or range over which a trait can be expressed with the exact level of expression being determined by environmental factors. With drug abuse the above process most likely includes polygenic involvement. The variation in phenotypical expression among drug abusers could be related to a number of specific inherited outcomes such as variations in drug activity, acute sensitivity,



tolerance development, withdrawal severity, or drug reinforcement (Collins & deFiebre, 1990).

Currently, research on genetics and other forms of drug abuse besides alcohol and nicotine addiction is not available. Such research is extremely difficult to do because of the illicit nature of other drugs and the much lower prevalence rate of their use by the general population. As Collins and deFiebre (1990) have noted the lack of data is due to the lack of research efforts not necessarily the lack of a causal relation.

The aforementioned disease model of drug abuse emphasizing genetics and biology has numerous advantages. It provides an easily definable construct for treatment and research and most people can fit the concepts of 'drug abuse' and 'disease' together as abnormal. Viewing abuse as a disease also allows health reimbursers to finance drug treatment as a medical condition and government health agencies to fund research on drug abuse etiology and treatment.

On the other hand, substantial weaknesses can be found with the disease model. As McKim (1991) states, "...the nature of the "disease" has never been identified. What sort of disease is it, and how can a disease make people take drugs?" (p. 66). In other words, unlike other genetic disorders, drug addiction requires some measure of active participation by the individual in the process of the disease. Szasz (1988)

considers drug abuse a "mythical disease". He argues that drugs are neutral and by themselves are neither good nor bad. The goodness or badness of drug consumption is the result of how individuals choose to use them. Szasz notes that what drug consumption is acceptable (i.e., alcohol, nicotine, caffeine, prescription drugs, etc.) and what is illegal or pathological (i.e., cocaine, heroin, etc.) are the result of political and social factors not medical science. Why is an alcoholic a diseased victim but a heroin addict a criminal? Peele (1988), coming from a similar perspective, argues:

The disease model has been so profitable and politically successful that it has spread to include problems of eating, child abuse, gambling, premenstrual tension, compulsive love affairs, and almost every other form of self-destructive behavior...From this perspective, nearly every American can be said to have a disease of addiction. (p. 67)

Irregardless of one's opinion on whether alcoholism or other forms of drug abuse are diseases per se, it is apparent that certain drugs can lead to physical dependence. For example, alcohol and opiate derivatives upon repeated administration produce changes within the central nervous system. Tolerance to these drugs does develop and abrupt cessation of



taking these drugs by a dependent person leads to withdrawal symptoms.

### Sociocultural Theories

According to these models drug taking behaviors, including drug abuse, are rooted in environmental factors. Differences in cultural norms, demographic patterns, group values, family systems, and socioeconomic conditions lead to variations in drug consumption and increased risk of drug abuse for some groups.

Attitudes toward the use of alcohol and other drugs varies across and within cultures (Leigh, 1985; Meyer, 1989; Peele, 1988; Vaillant, 1983). Those societies that encourage and accept heavy, binge consumption of alcohol, for example, have higher rates of alcoholism. On the other hand, Jewish and Italian American cultures encourage drinking limited to religious or family celebrations. In these cultures, heavy drinking is also discouraged with concomitant lower rates of alcoholism (Cahalan, 1978).

Bales (1946) argues that alcoholism is influenced by society in three ways (a) the attitudes toward drinking which the culture produces in its members, (b) the degree to which a culture causes acute needs for adjustment of inner tension in its members, and (c) the degree to which the society provides substitutes for drugs as a means of satisfaction. Nathan (1980) argues

that while cultural patterns may predispose the individual to alcoholism, social influence plays a role in the translation of this predisposition into alcohol abuse.

In summation, these theories argue that drug abuse is a social problem with roots in sociocultural factors. For example, ghetto environments infested with vermin, no jobs, and poor housing and recreation facilities are centers of hopelessness and despair. In American society, this disparaging environment is exacerbated by the large middle and upper class sections of society that surround the poorer areas. This isolation and segregation leads to apathy and ripe ground for escapism via drugs.

#### Psychological Theories

Most major schools of psychotherapy have offered theoretical models of drug abuse. As Doweiko (1990) notes "...psychological theories have postulated that chemical abuse and drug dependency were outgrowths of individuals [sic] attempts to come to terms with internal conflicts" (p. 157). We will now review the major psychological theories in drug abuse.

Psychoanalytic. In psychoanalytic terms drug dependency is a fixation within the individual at the oral stage of development. This fixation leads to an oral and narcissistic premorbid personality (Fields, 1992). Fenichel (1945) argued that individuals



consumed drugs to satisfy oral longing, security and the need to maintain self-esteem. Menninger (1963) saw alcohol as a coping mechanism to deal with the stress that resulted from being denied the milk of ones' mother during infancy. Drug abuse is an immature response of acting out as opposed to dealing with the real conflicts.

Recent psychoanalytic theory proposes a structural deficit in object relations. That is, individuals with poor impulse and emotional control have a difficult time establishing effective interpersonal relationships. Their defense mechanisms are established by defensive grandiosity (Fields, 1992). Other difficulties in object relations relate to (a) a defective stimulus barrier and an inability to demonstrate emotions, (b) the maladaptive narcissus of the addict, a defensive hand against rage and loneliness, and (c) impoverished self-esteem, the lack of selfcare and poor emotional regulation (Krystal & Raskin, 1970; Khantzian, 1978; Wurmser, 1978).

Adlerian. Adlerians focus on the perceived inferiority complex of the user. Neurotic symptoms develop as a safeguard for the individuals self-esteem (Schlaadt & Shannon, 1990). Steffenhagen (1974) explains that drug abuse is a compensatory maneuver due to a person's self-perception of inferiority and a desire to withdraw from social interaction. In this

scenario, drug taking becomes an excuse for failure - "If only I didn't have this drinking problem I could succeed" (Steffenhagen, 1974, p. 241).

Tension and stress models. It has been hypothesized that drug abuse may be an attempt by the individual to self-medicate emotional distress (Blane & Leonard, 1988). Gitlow (1985) believes people vary in their levels of tolerance to stress and stimulation. Some individuals are predisposed to drug abuse due to genetically programmed low stress thresholds. Gitlow (1985) argues that some people react as if a stimulus is stronger than it really is (i.e., stimulus augmentation). Research by Hennecke (1984) demonstrated that the sons of alcoholic fathers had a higher incidence of stimulus augmenters than sons of nonalcoholic fathers.

From a different perspective, individuals naturally experience varying levels of stress within their lives. It is possible that too much or too little stress in a person's life could predispose one to drug abuse (Fields, 1992). Too little stress could lead to lethargy and depression whereas too much stress could lead to anxiety. Excessive drug consumption could be attempts at relieving these discomforts. Koadel and Ravies (1989) argue that some individuals may use cocaine to relieve depression while Khantzian



(1985) suggests that certain individuals use narcotics to help control feelings of rage and aggression.

Behavioral models. These models are grounded on the principle of reinforcement. An individual self-administers a drug because it acts as a positive or negative reinforcer. Research with both animals and humans has shown drugs to have powerful reinforcement properties (McKim, 1991; Pickens & Thompson, 1968). The pharmacological properties of psychoactive drugs make their use pleasurable. Crowley (1988) argues that the nature, magnitude and schedule of the consequences of drug consumption may turn out to be more important than the antecedents of drug use in stopping drug dependency.

One concern with the positive reinforcement model is that not all of the consequences of drug consumption are pleasurable. Hangovers, familial disruption, cirrhosis, etc., are powerful negative outcomes of drug abuse. The central factor, however, seems to be timing. The closer the reinforcer is to an event, the stronger it is. With drug abuse the positive effects (i.e., stress relief, pleasure, etc.) are experienced shortly after the drug is consumed. Potential negative consequences come later and thus have weaker reinforcement power.

### An Overview of the Existential Perspective

Modern existential theory and therapy have roots in 19th century philosophy. During this time of the industrial revolution, the face of Europe was changing. People moved from rural to urban areas in search of jobs and wealth. Across Europe the stirring of political revolutions were starting to impact the dominant royal power structures which had been in place for over a millennia. The advance of technology and the freedom to travel and trade across the planet were spurred by and resulted in new perspectives on man's existence and his role in nature. Writers from Darwin to Freud rocked long held traditional axioms about the human condition with bold, new ideas. From these scientists and writers sprang the underpinnings of the existential movement. Philosophers such as Nietzsche, Dostoyevski, and Sartre mused on the basic human condition trying to understand the human experience.

Current existential approaches, while rooted in these historical and philosophical realities, are in fact a translation of philosophy into a mode of living. Individuals are seen as free to choose how they view and react to their worlds. Deterministic perspectives of human behavior are supplanted by individuals' abilities to decide their own actions while accepting personal responsibility for the resulting consequences. Existential theory thus seeks to challenge clients to



recognize their range of alternatives and choose among them. It is a growth model emphasizing human struggle to love and develop (Corey, 1991).

According to existentialists the following dimensions are key aspects of the human condition (a) the capacity for self-awareness, (b) freedom and responsibility, (c) creating one's identity and establishing meaningful relationships, (d) the search for meaning, (e) anxiety as a part of life, and (f) awareness of death and nonexistence (Corey, 1991). Human beings are seen as the only species on this planet possessing an awareness of their uniqueness as individuals separate from others. Such an awareness also leads to the realization that we are all at some level alone in this world. By freedom and responsibility, existentialists argue that people are free to choose their way in life but that they must assume responsibility for both their choices and the consequences of their choices. While people are not free to always control many aspects of their environment, they can choose how to react to it.

Through relationships with others, people also find meaning in life and a sense of connectedness. Aloneness need not lead to isolation. Though the richness of human intimacy, individuals can retain their sense of self (i.e., identity) while living in a interdependent social system. This search for meaning

appears to be another uniquely human characteristic. Existentialists argue that meaning in life is achieved via self-discovery. By loving, working, and creating with our peers and environment, people become aware of purpose in life. Meaning is therefore attainable as a by-product of being engaged with living (Corey, 1991).

Anxiety is considered part of the basic human condition; anxiety is the normal result of facing the stresses of life. The healthy individual faces anxiety as honestly and directly as possible. May (1981) notes that a certain amount of anxiety is the natural consequence of having the freedom to make choices:

We can escape the anxiety only by not venturing--that is by surrendering our freedom. I am convinced that many people never become aware of their most creative ideas since their inspirations are blocked off by this anxiety before the ideas even reach the level of consciousness. (p. 191)

Concomitant with the above characteristics humans must also face the reality of their own deaths. Such awareness, however, is seen as a source of enthusiasm for life. The knowledge of our own finiteness can motivate people to get the most out of life and the time they have.

Rubin (1990) notes that as humans we must come to accept death as part of our own condition. Unfortunately, he argues, current American society too



often denies and avoids death and dying. In the movie, "Jacobs Ladder", he states about accepting death - "If you've made your peace then the devils are really angels freeing you from this earth."

During this century, Viktor Frankl has become a major theorist and spokesperson for existential theory. Through his extraordinary personal life experiences which included spending three years in Nazi concentration camps, Frankl came to refine and translate existential ideas into guides for daily living. Frankl (1959) believes that the core of being human is in searching for meaning and purpose. From his personal experience he discovered that such meaning is often the outcome of love, work, and suffering. He also argues, along with earlier existential philosophers, that humans are free to choose their reactions to life - "...the last of human freedom--to choose one's attitude in any given set of circumstances, to choose one's own way" (p. 104).

Through his writings Frankl argues that humans can transcend their biological and social circumstances to a level of spirituality that allows them to create meaning in their lives. Logotherapy, Frankl's title for his vision of existential theory, is a method of assisting individuals in their search for meaning and happiness. Frankl (1967) feels that a search for meaning that is repressed or blocked will result in the

individual developing an "existential vacuum" (i.e., a feeling that life has no meaning or purpose). A person with such a vacuum experiences feelings of indifference, apathy or boredom, and a sense of meaninglessness with life. This existential vacuum is often the product of today's complex, impersonal world rather than specific pathology within the individual.

Frankl's major logotherapeutic constructs--will to meaning, existential vacuum, realities and potentialities, personal choice and responsibility, and death transcendence--form a cohesive existential model of both human behavior and therapeutic intervention. Frankl (1959) has hypothesized that addiction to drugs can be the direct result of a lack of meaning in one's life. Thus, an existential vacuum coupled with the constant bombardment of life's conflicts, can lead to the abuse of drugs as a source of relief. Viewed this way, drug abuse is self-treatment for internal discord.

Thus, the abuse of drugs is the result of basic human nature. To be human is to have the gifts of freedom and choice. However, concomitant with these attributes, is self-awareness or our sense of ultimately being alone in this world. The healthy, growing person faces this reality and uses it to build bridges with others and make contributions to our world. The drug abuser uses chemicals to avoid



recognition and acceptance of life's problems and suffering.

In addition to the preceding existential perspective, another pragmatic argument can be made for studying the relationship between meaning in life and drug abuse. Miller (1992) in arguing for the study of meaning and spirituality in relationship to drug abuse states:

At our present state of understanding we are accounting for but a minority of the variance in addictive behaviors and treatment outcomes through psychological, biological, and social variables combined. That is, most of the variability in onset process, and outcome of addictions is unexplained at present, and we can ill afford to ignore any class of variable with potential explanatory power. (p. 8)

Indeed, as a 1990 United States General Accounting Office report stated, "...researchers know little more about the best way to treat various drug addictions than they did 10 years ago" (Szasz, 1991, p. 4). Given this reality further exploration into the causes of drug abuse is warranted.

## Chapter 3

### METHODS

The purpose of this study was to assess the relationship between meaning in life and the occurrence of drug abuse. An epidemiological, retrospective study was performed to compare personal meaning in life between individuals receiving in-patient treatment for drug abuse and a group of matched, nondrug abusing controls.

#### Hypotheses

The following hypotheses were tested:

1. There will be no significant difference in meaning in life as measured by the Life Attitude Profile--Revised between drug abusers and matched controls.

2. There will be no significant difference in meaning in life as measured by the Purpose In Life test between drug abusers and matched controls.

#### Population

The population of interest are individuals receiving in-patient treatment for psychoactive substance abuse.

#### Sample Selection

Drug abusers, hereafter referred to as cases for this study, included all in-patient residents except those just starting or ending at the Buffalo Valley Treatment Facility and Tennessee Christian Treatment Facility between June 1, 1991 and June 30, 1991.



Nondrug abusing study participants, hereafter referred to as controls, were selected from employees at the Barren River Kentucky District Health Department and students/employees from Western Kentucky University. Prior to admission to this study as a control, individuals completed the Short Michigan Alcoholism Screening Test (SMAST) (Selzer, Vinokur, & Van Rooijen, 1975). Individuals scoring 3 or greater on this test were excluded from the control group.

#### Design

The study was an epidemiological, retrospective design. A sample of drug abusing cases were compared to a sample of nondrug abusing controls on self-reported measures of meaning in life. These self-reported measures included the Life Attitude Profile--Revised and the Purpose In Life test.

Individuals who were in residence for at least 72 hours completed the study questionnaires during their in-patient stay. This excluded patients who were in the process of detoxification and still had drugs in their systems. Patients completing the questionnaire during the last four days of treatment were excluded from the case group. This excluded patients who may have been experiencing the transitory, end of treatment euphoria common upon completion of in-patient drug treatment programs. All testing was performed by a PhD

psychologist or a graduate student in mental health counseling.

Controls were a sample of nondrug abusing individuals from the noninstitutionalized, American general population. Controls were matched to cases on age, race and gender. Specifically, after testing had been completed on the cases, an individual control participant was found for each case. Each control was in the same age category (i.e., case age plus or minus five years) and of the same gender and race as its corresponding case. Sites for control selection included the Barren River District Health Department and Western Kentucky University.

#### Instrumentation

##### Intake Date Form (IDF)

This is a brief questionnaire developed by this author in consultation with a psychologist to collect relevant participant information (Appendix A). It is a one page form which collects information on the following areas (a) demographic data, (b) past drug usage, and (c) family history of drug abuse.

##### Short Michigan Alcoholism Screening Test (SMAST)

The SMAST is a brief, screening instrument used to detect potential problem drinkers (Selzer et al., 1975) (Appendix B). The test is composed of 13 yes or no questions chosen as the most discriminating from the Michigan Alcohol Screening Test (MAST)



(Selzer, 1971). The SMAST consists of 13 items and an unweighted score of 0-13 is derived. A score of 0-1 is considered nonalcoholic, 2 is indicative of 'possible alcoholism', and 3 or greater is positive for alcoholism. The SMAST is a quick, simple instrument with demonstrated reliability and validity. It was developed to be used in screening high risk clients for potential alcohol problems. With three distinct comparison groups it correlated .93, .90 and .97 with the complete MAST (Selzer, Vinokur, & Van Rooijen, 1975).

Life Attitude Profile--Revised (LAP-R)

The LAP-R is a multidimensional instrument designed to measure Viktor Frankl's concepts of will to meaning, existential vacuum, personal choice and responsibility, realities and potentialities, and death transcendence (Frankl, 1959). Reker and Peacock (1981) developed the Life Attitude Profile (LAP) consisting of 56, seven point likert scale items measuring seven factorially derived dimensions of attitudes toward life. Internal consistency reliability estimates for these subscales range from .66 to .83 while the reliability for the entire test is .82. Test-retest reliability is .75 for the entire instrument and ranges from .56 to .83 for the subscales. Validity has been demonstrated by showing that six of the LAP subscales do not correlate

significantly with the Social Desirability Scale developed by Crowne and Marlowe (1964). LAP subscales also relate conceptually relevant measures such as internal/external locus of control, positive perception of life and death, positive self-concept, positive perception of the future, and alienation (Reker, 1991).

The LAP-R is a refined version of the original Life Attitude Profile (Reker, 1991). It is a multidimensional, self-report measure of attitudes toward life. The LAP-R consists of 36, seven point likert scale items and is scored and profiled in terms of six dimensions and two composite scales. The dimensions are (a) Purpose (PU), (b) Coherence (CO), (c) Existential Vacuum (EV), (d) Life Control (LC), (e) Death Acceptance (DA), and (f) Goal Seeking (GS). The two composite scales are Personal Meaning Index (PMI) and Life Attitude Balance Index (LABI). The PMI is a two-component construct including having life goals; having a mission in life; having a sense of direction from past; present and future; and having a logically consistent and integrated understanding of self, others, and life in general. The LABI is a global measure of attitudes about life that includes the degree to which meaning and purpose have been discovered and the motivation to find meaning and purpose. Internal consistency reliability for the



LAP-R dimensions and composite scores range from .63 to .87 (Reker, 1991).

The LAP-R is scored in a straight forward manner ranging from 1 (strongly disagree) to 7 (strongly disagree). By adding item scores for the respective dimensions scale scores are produced. Composite scale scores for the Integrity Index range from -60 to 156 while scores for the PMI range from 12 to 84. The dimension scale scores for Purpose, Coherence, Existential Vacuum, Life Control, Death Acceptance, and Goal Seeking range from 6 to 42, respectively (Reker, 1991).

#### Purpose In Life (PIL)

The PIL test is a 20 item, seven point Likert scale test which purports to measure self-perception of one's purpose in life (Crumbaugh & Maholick, 1968). Item development for the test was grounded in existential principles with particular attention to logotherapy. Individuals are assumed capable of consciously approximating their real life attitudes through self-reflection.

Internal consistency reliability estimation for the PIL determined by the odd-even method with the Spearman-Brown correction formula was .90 (Crumbaugh & Maholick, 1968). Crumbaugh and Maholick (1968) demonstrated construct validity for the PIL by successfully demonstrating that the instrument

significantly discriminated between mental health patients and non-patient controls. In order to avoid position preferences and 'halo' effects, the direction of magnitude is randomized for all items.

#### Data Analysis

Data were transcribed into a computer data file and analyzed using the Statistical Analysis System (SAS).

#### Variables

The independent variable is drug abuse. The scores on the LAP-R and PIL are the dependent variables.

#### Statistical Procedures

Research Hypothesis 1: There will be no significant difference in meaning in life as measured by the Life Attitude Profile--Revised between drug abusers and matched controls.

Multivariate analysis of variance (MANOVA) was performed to compare scores between the case and control groups. The MANOVA constructed global score was compared between the two groups as well as scores on the six dimension scales and two composite scales.

Research Hypothesis 2: There will be no significant difference in meaning in life as measured by the Purpose In Life test between drug abusers and matched controls.



Analysis of variance (ANOVA) was performed to compare scores between the drug abuser and matched control group.

## Chapter 4

### RESULTS

#### Description of Study Sample

A total of 98 individuals participated in the study as cases (n=49) or controls (n=49). The mean age of the case group was 29.4 years (Standard Deviation=8.8; Range=14 years to 48 years) The mean age of the control group was 29.1 years (Standard Deviation=9.2; Range=18 years to 49 years). The gender and race proportions were identical for both groups. Of the 49 subjects in each group, 29 (59.2%) were male and 20 (40.8%) were female. The breakdown by race was 85.7% white (n=42), 12.2% black (n=6) and 2% Hispanic (n=1).

The mean time in treatment for the cases was 14.1 days (Standard Deviation=9.7; Range=3 days to 43 days). Of the 49 cases, 38 (77.6%) were from the Buffalo Valley Treatment Facility and 11 (22.4%) were from the Tennessee Christian Treatment Facility.

Members of the case group were more likely to report a family history of alcoholism. Of the 49 case subjects, 39 (79.6%) reported a family history of alcoholism while 18 (36.7%) from the control group reported a family history of alcoholism,  $\chi^2 (1, N=98)=18.49, p<.001$ . This chi square value converted to a Phi Coefficient of .43.



### Descriptive Data

Data on the subjects test scores on the Purpose In Life test are summarized in Table 1. Table 1 displays the sample size, group mean, standard deviation and range on the PIL for the case and control groups. The PIL scores were significantly higher in the control group as compared with the case group.

Summary statistics on the subjects test scores on the subscales of the LAP-R are summarized in Table 2. As compared to the case group, the control group had significantly higher levels of subjective meaning in life in the areas of Purpose in Life, Control of One's Life and Acceptance of Death. Control subjects also displayed a significantly lower level Existential Vacuum ideation as compared with the cases. No significant differences were found between cases and controls on the dimensions of Coherence and Goal Seeking. On both composite scales (Personal Meaning Index and Life Attitude Balance Index) control subjects had significantly higher mean scores indicative of more meaning of life.

### Tests of Hypotheses

#### Research Hypothesis 1

The first hypothesis was there will be no significant difference in meaning in life as measured by the Life Attitude Profile--Revised between drug abusers and matched controls. To test this hypothesis,

Table 1

Descriptive Statistics on the Purpose In Life test

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	<u>n</u>	<u><math>\bar{X}</math>*</u>	<u>SD</u>	<u>Range</u>
Cases	49	79.0	9.0	62-100
Controls	49	83.5	5.5	66-94

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\* $F(1, 96) = 8.64, p < .01$

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a multivariate analysis of variance (MANOVA) was performed comparing LAR-R scores between the case and control groups. As can be seen in Table 2, a significant overall group difference was found between the two study groups on the LAP-R,  $F(7,90) = 8.69$ ,  $p < .001$ . Results of the General Linear Models Procedure for comparing both study groups on the LAP-R subscales are also reported on Table 2. An examination of these results reveals that the control group had significantly higher levels of subjective meaning in life on the following dimensions: (a) Purpose,  $F(1, 96) = 32.98$ ,  $p < .001$ ; (b) Life Control,  $F(1, 96) = 6.71$ ,  $p < .05$ ; and (c) Death Acceptance,  $F(1, 96) = 5.27$ ,  $p < .05$ . Consistent with these results, controls had significantly lower levels of feelings of Existential Vacuum,  $F(1, 96) = 25.28$ ,  $p < .001$ . Also, controls had significantly more meaning in life than the cases on the composite Personal Meaning Index,  $F(1, 96) = 14.47$ ,  $p < .001$  and Life Attitude Balance Index,  $F(1, 96) = 22.34$ ,  $p < .001$ .

Based on these tests, we find mixed results regarding Research Hypothesis 1. The null hypothesis of no overall difference between groups was rejected (i.e., significant overall difference on the MANOVA constructed global score). The null hypothesis was also rejected on four of the dimension scales (Purpose,

Table 2

Descriptive and Inferential Statistics on the Life Attitude Profile--Revised (n=49 for all values)

<u>LAP-R</u>	<u>Study Group</u>						<u>F</u>	<u>Sign.</u>
	<u>Cases</u>			<u>Controls</u>				
<u>Dimensions</u>	<u><math>\bar{X}</math></u>	<u>SD</u>	<u>Range</u>	<u><math>\bar{X}</math></u>	<u>SD</u>	<u>Range</u>		
Purpose	24.1	7.6	8-42	31.9	5.8	18-42	32.98	.001*
Coherence	31.4	7.0	13-42	32.7	5.9	18-42	1.04	ns*
<u>Existential</u>								
Vacuum	30.0	7.5	9-41	22.3	7.6	6-35	25.28	.001*
Life Control	30.9	7.2	12-42	34.1	4.6	24-42	6.71	.05*
<u>Death</u>								
Acceptance	25.1	6.9	12-42	28.3	6.6	12-41	5.27	.05*
Goal Seeking	33.1	5.6	17-42	32.8	5.2	23-42	.07	ns*
<u>Composite Scales</u>								
<u>Personal</u>								
Meaning	55.5	13.1	25-81	64.6	10.6	36-84	14.47	.001*
<u>Index</u>								
<u>Life</u>								
Attitude	48.4	24.4	-8-113	71.4	23.8	21-131	22.34	.001*
<u>Balance</u>								
<u>Index</u>								

\*df=1, 96

Note. Wilks' Lambda=.5968;  $F(7, 90) = 8.69, p < .001$

(i.e., MANOVA Test Criteria and Exact F statistic for the Hypothesis of no Overall Group Effort)



Existential Vacuum, Life Control, Death Acceptance) and both of the composite scales. However, the null hypothesis was accepted for the dimension scales of Coherence and Goal Seeking.

#### Research Hypothesis 2

There will be no significant difference in meaning in life as measured by the Purpose In Life test between drug abusers and matched controls. An analysis of variance was performed comparing case to control subjects on the PIL total score. The mean score for the controls ( $X=83.5$ ; Standard Deviation= $5.5$ ) was significantly higher than the mean scores for the cases ( $X=79.0$ ; Standard Deviation= $9.0$ ),  $F(1, 96) = 8.64$ ,  $p < .01$ . Based on these results the null hypothesis of no significant difference between the two groups on the PIL was rejected.

## Chapter 5

### CONCLUSION

An epidemiological, retrospective study was performed to compare personal meaning in life between individuals receiving in-patient treatment for drug abuse and a group of matched, nondrug abusing controls. Subjects completed the Purpose In Life test and the Life Attitude Profile--Revised.

#### Summary of Results

There was an overall, significant difference between case and control subjects on the LAP-R. Control subjects evidenced a higher, overall level of meaning in life. On the six dimension scales, controls had significantly higher levels of life meaning as evidenced by higher scores on the Purpose, Life Control, and Death Acceptance scales and lower scores on the Existential Vacuum scale. On the remaining dimensions (i.e., Coherence and Goal Seeking) no difference was found between cases and controls.

A significant difference was also found between cases and controls on the two composite scales. Controls had higher scores on the Personal Meaning Index and the Life Attitude Balance Index.

There was a significant difference between the case and control groups on the PIL. Control subjects



had a higher level of subjective meaning in life as evidenced by significantly higher PIL scores when compared with the case subjects.

#### Discussion

The major problem encountered during this project was finding appropriate age, race and gender controls to match with suitable case subjects. A total of 98 in-patient drug treatment patients initially completed the survey questionnaires. Of these, 5 (5.1%) were excluded from the study because they had been in treatment less than 72 hours. Initially, there were 160 potential control subjects tested. From this sample, 15 (9.4%) were excluded from the study for having SMAST scores in the Alcoholic category. From the remaining 93 in-patient drug abusers and 145 potential controls 49 pairs could be matched on gender, race and age ( $\pm$  5 years).

Another problem encountered during this project involved the utilization of the Short Michigan Alcohol Screening Test (SMAST) to screen out potential alcoholics from the control group. The SMAST was developed to be used with admissions to drug treatment facilities and by physicians to use on ambulatory patients who are suspected of an alcohol problem. The SMAST thus has sensitivity (i.e., the ability to detect someone as alcoholic if they truly are alcoholic). However, to achieve this, the SMAST specificity (i.e.,

to accurately label as alcoholics only true alcoholics) is considerably lower. Thus, a number of non-alcoholic individuals are incorrectly labeled as alcoholic. With the high-risk population for which this test was developed this problem is minimized. Such is not the case, however, with a sample from the general population.

During the process of testing potential control subjects the following two questions from the SMAST posed problems. Question number one is--Do you feel you are a normal drinker? The 'alcoholic' response to this is NO while the 'non-alcoholic' response is YES. Several individuals who didn't drink at all, however, responded with 'NO' (i.e., they don't drink so they're not normal drinkers). Question number six is--Have you ever attended a meeting of Alcoholics Anonymous? A 'YES' is the alcoholic response while a 'NO' is the non-alcoholic response. However, one control subject who doesn't drink at all answered yes to this because he had gone to AA meetings as a health professional to observe.

It is impossible to tell how many potential controls were incorrectly labeled as alcoholic and eliminated from the study. An indirect 'guesstimate' follows. Roughly, two thirds of American adults drink (i.e., 67% of 160 potential controls in this study equals 107.3 people). Of these Americans who drink an



estimated 10% are 'problem drinkers' (i.e., 10% of 107.2 equals 10.7 people). Our sample of controls, however, could arguably have a lower proportion of alcoholics than the American population. Specifically, roughly 75% of the potential controls screened were females and females have lower rates of alcoholism. Secondly, all controls were taken from the South Central Kentucky area in the heart of the Bible belt. Drinking rates are lower in this area as compared to the general U.S. population. Given these realities this author estimated that 5 to 8 out of the original 160 potential controls were alcoholic. The SMAST, however, screened out 15 of these controls and thus most probably eliminated 7 to 10 non-alcoholic, usable control subjects.

The final problem encountered with this research was achieving access to in-patient drug treatment facilities. For this study, access was achieved only through professional networking. That is a 'friend of a friend' had worked in certain facilities and was able to get in to test patients.

#### Limitations

The major limitation of this study involves the testing of the case subjects (i.e., drug abusers) after they had developed a drug problem. As noted in the results, significant differences in meaning in life were found between the cases and controls. Whether

these differences existed before the cases developed their drug problem is impossible to determine from this study.

Another limitation was the possibility of incorrectly labeling some of the control subjects. The SMAST screened out potential alcoholics but not persons with other drug problems. The results showed significant differences were found between cases and controls. If this bias did occur, it only served to lessen the observed differences in scores between cases and controls. Thus, the direction of the results found are probably accurate but the strength of the relationship may be attenuated.

#### Conclusions

Within the context of this study and its limitations, the in-patient drug abusing subjects were found to have significantly different levels of meaning in life when compared to matched, nondrug abusing controls. Comparisons with the PIL indicated that control subjects had a higher amount of self perceived purpose in life. However, it should be noted that the differences in the mean score were modest.

Conclusions based on the LAP-R were mixed. Cases had significantly more meaning in life as evidenced by their scores on the LAP-R scales of Life Purpose, Life Control, Death Acceptance, Existential Vacuum, Personal Meaning, and Life Attitude Balance. No differences



were found between cases and controls on the scales of Coherence and Goal Seeking.

The Life Purpose scale measures zest for life, contentment, and life satisfaction. A sample item is "Basically, I am living the kind of life I want to live." The control subjects' mean score ( $\bar{X}=31.9$ ) was notably higher than the cases' mean score ( $\bar{X}=24.1$ ). Thus, drug abusers appear to be substantially less happy with the life they are living when compared with nondrug abusers. The Life Control scale measures a person's freedom to make life choices and exercise self-responsibility. A sample item is "My life is in my hands and I am in control of it." The differences in scores on this scale were modest (i.e., cases:  $\bar{X}=30.9$ ; controls:  $\bar{X}=34.1$ ). But drug abusers do appear to feel less in control of their lives. The Death Acceptance scale measures death transcendence or a mental acceptance of death. The case subjects' scores ( $\bar{X}=25.1$ ) were significantly but only slightly lower than the control subjects' scores ( $\bar{X}=28.3$ ). This could be interpreted as no matter what the relationship between meaning in life and drug abuse, attitudes toward death are not a major factor. Two other explanations are age factors and an alternative orientation. The mean age of subjects in this study was roughly 29. Fear of death often doesn't appear until later in life. However, acceptance of one's

eventual death is generally seen as realistic and thus mentally healthy. An argument could be made, especially if one does not believe in life after death, that death acceptance is irrational and it is better to fight it. The Existential Vacuum scales measure lack of purpose and goals in life along with boredom and apathy. A sample question is "I feel the lack of and a need to find real meaning and purpose in my life." The case subjects mean score ( $\bar{X}=30.0$ ) was substantially higher than the control subjects mean score ( $\bar{X}=22.3$ ). These drug abusers, at least, are experiencing a substantial void in their lives.

The Personal Meaning Index is a dual-component construct made up of having: (a) a logically integrated and consistent understanding of self, others, and life in general; (b) life goals; (c) a life mission; and (d) a sense of one's past, present, and future. The case groups scores ( $\bar{X}=55.5$ ) were notably lower than the control groups scores ( $\bar{X}=64.6$ ). Drug abusers appear to differ substantially on this aspect of life meaning. The Life Attitude Balance Index takes into account the degree to which meaning and purpose have been discovered and the motivation to find meaning and purpose. This is thus a global measure of attitude towards life. The difference between case scores ( $\bar{X}=48.4$ ) and control scores ( $\bar{X}=71.4$ ) was dramatic. Drug abusers are apparently substantially lacking in this construct.



Interestingly, no difference was found between case subject scores ( $X=31.4$ ) and control subject scores ( $X=32.7$ ) on the Coherence Scale. This scale measures having a logically integrated and intuitive understanding of self, others, and life in general. A sample question is "The meaning in life is evident in the world around us."

There was also no difference found between case scores ( $X=33.1$ ) and control scores ( $X=32.8$ ) on the Goal Seeking scale. This scale measures one's desire to get away from the routine of life, to search for new and different experiences, and to get more out of life. Of note is the fact that this was the only scale where the case groups observed scores were actually higher (i.e., and thus possibly better) than the control groups. The author is hesitant about drawing potentially significant findings from technically nonsignificant analyses. However, a plausible explanation is possible for their potential relationship. It could be argued that since these drug abusers were in treatment, actively involved in trying to change their lives, they were experiencing goal seeking behavior (i.e., the goal of a nondrug abusing life). If this were true it would be interesting to know if their goal seeking desire developed before or after entrance into treatment.

Given the aforementioned results it is apparent that real differences exist between drug abusers and nondrug abusers in various dimensions of meaning or purpose in life. The extent to which these differences existed before the onset of drug abusing behavior is unattainable within the context of the current study.

#### Implications

1. Individuals who enter in-patient facilities for drug abuse differ from nondrug abusing adults in their subjective assessment of life's meaning. Specifically, drug abusers appear to have a more negative attitude toward life.
2. Drug treatment programs which include programs or environments geared toward explanation of an individual's perception of life's meaning may have an advantage over programs that don't.
3. Primary prevention programs which include programs or environments geared toward explanation of an individual's perception of life's meaning may have an advantage over programs that don't.
4. Drug treatment programs might consider accentuating Goal Seeking strategies.

#### Recommendations

1. Future research should attempt to replicate these research findings.



2. Future research should explore in greater detail and with a larger sample drug abusers' subjective assessments of life's meaning.

3. Drug treatment programs should consider the addition of existential principles to their treatment paradigms.

4. Existential treatment models should be tested against current treatment approaches.

## References

- American Public Health Association. (1989). A public health response to the war on drugs: Reducing alcohol, tobacco and other drug problems among the nations youth (Policy Statement No. 8817). Washington, D.C.: Author.
- Bales, R. (1946). Cultural differences in rates of alcoholism. Quarterly Journal of Studies of Alcohol, 6, 460-499.
- Blum, K., Noble, E., Sheridan, P., Montgomery, A., Ritchie, T., Jagadeeswaran, P., Nogami, H., Briggs, A., & Cohn, J. (1990). Allelic association of human dysamine D2 receptor gene in alcoholism. Journal of American Medical Association, 15, 263.
- Blane, H., & Leonard, K. (Eds). (1988). Psychological theories of drinking and alcoholism. New York: Guilford Press.
- Brook, J., Whitman, M., Gordon, A., & Cohen, P. (1986). Dynamics of childhood and adolescent personality traits and adolescent drug use. Developmental Psychology, 22, 403-414.
- Cahalan, D. (1979). Implications of american drinking practices and attitudes for prevention and treatment of alcoholism. In G. Marlatt & P. Nathan (Eds.), Behavioral approaches to alcoholism (pp. 291-315). New Jersey: Rutgers University.



- Carroll, C. (1989). Drugs in Modern Society (2nd ed.). Dubuque, Iowa: William C. Brown Publishers.
- Clifford, P. (1991, December). The Center for Alcohol and Addiction Studies. Personal correspondence.
- Cloninger, C., Bohman, M., & Sigvardsson, S. (1981). Inheritance of alcohol abuse. Archives of General Psychology, 38, 861-868.
- Collins, A., & deFiebre, R. (1990). A review of genetic influences on psychoactive substance use and abuse in treatment choices for alcoholism and substance abuse. Lexington, Mass.: Lexington Books.
- Corey, G. (1991). Theory and practice of counseling and psychotherapy (4th ed.). Pacific Grove, California: Brooks/Cole Publishers.
- Crowly, T. (1988, November). Substance abuse treatment and policy: Contributions to behavioral pharmacology. Paper presented at the annual meeting of the American Psychological Association, Atlanta, GA.
- Crowne, D., & Marlowe, D. (1964). The Approval Motive. New York: Wiley.
- Crumbaugh, J., & Maholick, L. (1968). Cross-validation of the purpose in life test based on Frankl's concepts. Journal of Individual Psychology, 24, 74-81.
- Department of Health and Human Services. (1987). Alcohol and health: A special report to the US Congress. (DHHS Publication No. ADM 87-1519). Washington, DC: U.S. Government Printing Office.

- Department of Health and Human Services. (1988). The health consequences of smoking - Nicotine addiction a report to the surgeon general. (DHHS Publication No. 017-001-00468-5). Washington, DC: U.S. Government Printing Office.
- Department of Health and Human Services. (1989). Smoking, tobacco and health. (DHHS Publication No. CDC 87-8397). Washington, DC: U.S. Government Printing Office.
- Doweiko, H. (1990). Concepts of chemical dependency. California: Brooks/Cole Publishing Company.
- Duncan, D., & Gold, R. (1982). Drugs and the whole person. New York: John Wiley & Sons.
- Fenichel, O. (1945). The psychoanalytic theory of neurosis. New York: W. W. Norton.
- Fields, R. (1992). Drugs and alcohol in perspective. Dubuque, Iowa: William C. Brown Publisher.
- Frankl, V. (1959). Man's search for meaning. New York: Washington Square Press.
- Frankl, V. (1967). Psychotherapy and existentialism - Selected papers on logotherapy. New York: Washington Square Press.
- Gitlow, S. (1985). Considerations on the evaluation and treatment of substance dependency. Journal of Substance Abuse Treatment, 2, 175-179.
- Goodwin, D. (1971). Is alcoholism hereditary: A review and critique. Archives of General Psychology, 25, 545-549.



- Hennecke, L. (1984). Stimulus augmenting and field dependence in children of alcoholic fathers. Journal of Studies on Alcoholism, 45, 486-92.
- Heimann, R. (1960). Tobacco and americans. New York: McGraw Hill Book Co.
- Huber, E., & Omenn, G. (1981). Evidence of genetic predisposition to alcoholic cirrhosis and psychosis twin concordance for alcoholism and its end points by zygosity among male veterans. Alcoholism, 5, 207-215.
- Irwin, S. (1973). A rational approach to drug abuse prevention. Contemporary Drug Problems, 2, 3-46.
- It doesn't have to be like this (1989, September). The Economist, p. 21-24.
- Jellinek, E. (1960). The disease concept of alcoholism. New Haven, CT: College Review Press.
- Kaij, L. (1960). Alcoholism and twins. Studies in the etiology and sequela of abuse of alcohol. Stockholm: Alongrust and Winkell Publisher.
- Kandel, D. (1974). Interpersonal influence on adolescent illegal drug use. In E. Josephson & E.E. Carroll (Eds.), Drug use: Epidemiological and sociological approaches (pp. 207-240). Washington, DC: Hemisphere.
- Kandel, D., Kessler, R., & Marquies, R. (1970). Antecedents of adolescents initiation into stages of drug use: A development analysis. In D.B. Kandel (Ed.), Longitudinal research on drug use (pp. 370-392). Washington, DC: Hemisphere Publisher.

- Kandel, D., & Raveis, V. (1989). Cessation of illicit drug use in young adulthood. Archives of General Psychology, 46, 109-116.
- Khantzian, E. (1978). The ego, the self and opiate addiction: Theoretical and treatment consideration. International review of psychoanalysis, 5, 189-198.
- Khantzian, E. (1985). The self-medication hypothesis of additional disorders: Focus on heroin and cocaine dependence. American Journal of Psychology, 142, 1259-1264.
- Krystal, H., & Raskin, H. (1970). Drug dependence: Aspects of ego functions. Detroit: Wayne State Press University.
- Labouvre, E., & McGee, C. (1986). Relation of personality to alcohol and drug use in adolescence. Journal of Consulting and Clinical Psychology, 54, 289-293.
- Leigh, G. (1985). Psychosocial factors in the etiology of substance abuse. In Brather, T. & Forrest, G. (Eds.), Alcoholism and substance abuse: Strategies for clinical intervention (pp. 141-179). New York: The Free Press.
- Lord, J. (1987, June). Coming to grips with alcoholism. US News and World Report, p. 56.
- May, R. (1981). Freedom and destiny. New York: Norton Publisher.
- McKim, W. (1991). Drugs and behavior - An introduction to behavioral pharmacology (2nd ed.). Englewood Cliff, New Jersey: Prentice Hall.



- Menninger, K. (1963). The vital balance. New York: Viking Press.
- Meyer, R. (1989). Who can say no to illicit drug use? Archives of General Psychiatry, 46, 189-190.
- Miller, W. (1992). Spirituality: The silent dimension of addictions research. Unpublished Manuscript.
- Musto, D. (1989). America's first cocaine epidemic. The Wilson Quarterly, 59-64.
- Nathan, P. (1980). Etiology and process in additive behaviors. New York: Pergaman Press.
- National Institute on Drug Abuse. (1985). National household survey on drug abuse: Main findings. (DHHS Publication No. ADM 88-1586). Washington, DC: U.S. Government Printing Office.
- National Interagency Council on Smoking and Health. (1984). American council on science and health bills tobacco industry. Smoking and Health Reporter, 1 No. 4.
- Peele, S. (1988). On the diseasing of america. Utne Reader, 30, 67.
- Pickens, R., & Thompson, T. (1968). Cocaine reinforced behavior in rats: Effects of reinforcement magnitude and fixed-ratio size. Journal of pharmacology and experimental therapeutics, 161, 122-129.
- Ray, O., & Ksir, C. (1990). Drugs, society and human behavior. Boston: Times Mirror/Mosby College Publisher.
- Reker, G. (1991). The LAP and LAP-R provisional procedures manual. Ontario: Trent University.

- Reker, G., & Peacock, E. (1981). The Life Attitude Profile (LAP): A multidimensional instrument for assessing attitudes toward life. Canadian Journal of Behavioral Science, 13, 264-273.
- Rubin, B. (Writer), Kassar, M. & Vajna, A. (Executive Producers). Line, A. (Director). (1990). Jacobs Ladder [Film]. Carolco Pictures Inc., New York.
- Rubins, L. (1978). Study childhood predictors of adult antisocial behavior: Replication from longitudinal studies. Psychology Medical, 8, 183-191.
- Rucker, W., & Rucker, M. (1989). Drugs, society and behavior Annual Edition. Connecticut: Dishkin Publisher Group.
- Scott, J. (1969). The white poppy - A history of opium. New York: Funk and Wagnall.
- Schlaadt, R., & Shannon, P. (1990). Drugs (3rd Ed.). Englewood Cliffs, New Jersey: Prentice Hall.
- Selzer, M., Vinokur, A. & Van Rooijen, L. (1975). A self administered Short Version of the Michigan Alcohol Screening Test (SMAST). Journal of Studies on Alcohol, 36, 117-126.
- Selzer, M. (1971). The Michigan Alcohol Screening Test; the quest for a new diagnostic instrument. American Journal of Psychiatry, 127, 1653-1658.
- Snyder, S. (1970). What have we forgotten about pot. Time Magazine, pp. 121,124,130.



- Steffenhagen, R. (1974). Drug abuse and related phenomenon: An Adlerian Approach. Journal of Individual Psychology, 302, 240-241.
- Stewart, G. (1967). A history of medical uses of tobacco. Medical History, 11, 228-268.
- Szasz, T. (1988). A plea for the cessation of the longest war of the twentieth century - The war on drugs. The Humanist Psychologist, 16, 314-322.
- Szasz, T. (1991). The myth of treatment in the drug policy letters. The Drug Policy Foundation Washington, 3, No. 4.
- The Holy Bible (The New King James Version). (1983). Nashville, TN: Thomas Nelson Publishers.
- Vaillant, G. (1983). The natural history of alcoholism. Cambridge, Mass.: Harvard University Press.
- White, J. (1991). Drug dependence. Englewood Cliffs, New Jersey: Prentice Hall.
- Wurmser, L. (1978). Psychoanalytic considerations of the etiology of compulsive drug use. Journal of American Psychoanalytic Association, 22; 820-843.
- Zucker, R., & Gomberg, E. (1986). Etiology of alcoholism reconsidered: The case for biopsychosocial process. American Psychologist, 41, 783-793.

Appendix A  
Intake Data Form

1. Facility: \_\_\_\_\_
2. Date of Birth: \_\_\_\_\_
3. Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female
4. Race: \_\_\_\_\_ Black \_\_\_\_\_ Oriental  
\_\_\_\_\_ White \_\_\_\_\_ Native American  
\_\_\_\_\_ Hispanic \_\_\_\_\_ Other
5. The total Family Income in your Household for this year is:  
(check one)
- \_\_\_\_\_ 15,000 or less  
\_\_\_\_\_ 15,001 to 30,000  
\_\_\_\_\_ 30,001 to 45,000  
\_\_\_\_\_ 45,001 to 60,000  
\_\_\_\_\_ Greater than 60,001
6. Family History of Alcoholism? \_\_\_\_\_ yes \_\_\_\_\_ no



Questions 1 through 13 ask about your drinking habits. Check the YES or NO headings to answer each question.

Short Michigan Alcohol Screening Test		YES	NO
1.	Do you feel you are a normal drinker? (By normal, we mean you drink less than or as much as most other people)	_____	_____
2.	Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	_____	_____
3.	Do you ever feel guilty about your drinking?	_____	_____
4.	Do friends or relatives think you are a normal drinker?	_____	_____
5.	Are you able to stop drinking when you want to?	_____	_____
6.	Have you ever attended a meeting of Alcoholics Anonymous?	_____	_____
7.	Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?	_____	_____
8.	Have you ever gotten into trouble at work because of drinking?	_____	_____
9.	Have you ever neglected your obligations, your family, or your work for two or more days in a row, because you were drinking?	_____	_____
10.	Have you ever gone to anyone for help about your drinking?	_____	_____
11.	Have you ever been in the hospital because of drinking?	_____	_____
12.	Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?	_____	_____
13.	Have you ever been arrested, even for a few hours, because of other drunken behavior?	_____	_____

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Classification \_\_\_\_\_

**P I L**

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**PART A**

For each of the following statements, circle the number that would be most nearly true for you. Note that the numbers always extend from one extreme feeling to its opposite kind of feeling. "Neutral" implies no judgment either way; try to use this rating as little as possible.

1. I am usually:

1	2	3	4	5	6	7
completely bored			(neutral)			exuberant, enthusiastic

2. Life to me seems:

7	6	5	4	3	2	1
always exciting			(neutral)			completely routine

3. In life I have:

1	2	3	4	5	6	7
no goals or aims at all			(neutral)			Very clear goals and aims

4. My personal existence is:

1	2	3	4	5	6	7
Utterly meaningless without purpose			(neutral)			very purposeful and meaningful

5. Every day is:

7	6	5	4	3	2	1
constantly new			(neutral)			exactly the same

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**PSYCHOMETRIC AFFILIATES**

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Test #168  
FORM A



6. If I could choose, I would:  
 1 2 3 4 5 6 7  
 prefer never to (neutral) Like nine more  
 have been born lives just like  
 this one
7. After retiring, I would:  
 7 6 5 4 3 2 1  
 do some of the exciting (neutral) loaf completely  
 things I have always wanted to the rest of my life
8. In achieving life goals I have:  
 1 2 3 4 5 6 7  
 made no progress (neutral) progressed to com-  
 whatever plete fulfillment
9. My life is:  
 1 2 3 4 5 6 7  
 empty, filled only (neutral) running over with  
 with despair exciting good things
10. If I should die today, I would feel that my life has been:  
 7 6 5 4 3 2 1  
 very worthwhile (neutral) completely  
 worthless
11. In thinking of my life, I:  
 1 2 3 4 5 6 7  
 often wonder (neutral) always see a  
 why I exist reason for my  
 being here
12. As I view the world in relation to my life, the world:  
 1 2 3 4 5 6 7  
 completely confuses me (neutral) fits meaningfully  
 with my life
13. I am a:  
 1 2 3 4 5 6 7  
 very irresponsible (neutral) very responsible  
 person person

14. Concerning man's freedom to make his own choices, I believe man is
- |   |   |   |           |   |   |   |
|---|---|---|-----------|---|---|---|
| 7   | 6 | 5 | 4         | 3   | 2 | 1 |
| absolutely free to<br>make all life choices |   |   | (neutral) | completely bound by<br>limitations of heredity<br>and environment |   |   |
15. With regard to death, I am:
- |                          |   |   |           |                              |   |   |
|--------------------------|---|---|-----------|------------------------------|---|---|
| 7                        | 6 | 5 | 4         | 3                            | 2 | 1 |
| prepared and<br>unafraid |   |   | (neutral) | unprepared and<br>frightened |   |   |
16. With regard to suicide, I have:
- |   |   |   |           |                                    |   |   |
|---|---|---|-----------|------------------------------------|---|---|
| 1                                       | 2 | 3 | 4         | 5                                  | 6 | 7 |
| thought of it seriously<br>as a way out |   |   | (neutral) | never given it a<br>second thought |   |   |
17. I regard my ability to find a meaning, purpose, or mission in life as:
- |            |   |   |           |                  |   |   |
|------------|---|---|-----------|------------------|---|---|
| 7          | 6 | 5 | 4         | 3                | 2 | 1 |
| very great |   |   | (neutral) | practically none |   |   |
18. My life is:
- |  |   |   |           |  |   |   |
|--|---|---|-----------|--|---|---|
| 7  | 6 | 5 | 4         | 3  | 2 | 1 |
| in my hands and I<br>am in control of it |   |   | (neutral) | out of my hands<br>and controlled<br>by external factors |   |   |
19. Facing my daily tasks is:
- |  |   |   |           |                                      |   |   |
|--|---|---|-----------|--------------------------------------|---|---|
| 7  | 6 | 5 | 4         | 3                                    | 2 | 1 |
| a source of pleasure<br>and satisfaction |   |   | (neutral) | a painful and bor-<br>ing experience |   |   |
20. I have discovered:
- |                                  |   |   |           |   |   |   |
|----------------------------------|---|---|-----------|---|---|---|
| 1                                | 2 | 3 | 4         | 5   | 6 | 7 |
| no mission or<br>purpose in life |   |   | (neutral) | clear-cut goals<br>and a satisfying<br>life purpose |   |   |



LIFE ATTITUDE PROFILE-REVISED (LAP-R)

(C) Gary T. Reker

This questionnaire contains a number of statements related to opinions and feelings about yourself and life in general. Read each statement carefully, then indicate the extent to which you agree or disagree by circling one of the alternative categories provided. For example, if you **STRONGLY AGREE**, circle SA following the statement. If you **MODERATELY DISAGREE**, circle MD. If you are **UNDECIDED**, circle U. Try to use the **UNDECIDED** category sparingly.

-----

SA	A	MA	U	MD	D	SD
STRONGLY	AGREE	MODERATELY	UNDECIDED	MODERATELY	DISAGREE	STRONGLY
AGREE		AGREE		DISAGREE		DISAGREE

- |     |  |    |   |    |   |    |   |    |
|-----|--|----|---|----|---|----|---|----|
| 1.  | My past achievements have given my life meaning and purpose.                 | SA | A | MA | U | MD | D | SD |
| 2.  | In my life I have very clear goals and aims.                                 | SA | A | MA | U | MD | D | SD |
| 3.  | I regard the opportunity to direct my life as very important.                | SA | A | MA | U | MD | D | SD |
| 4.  | I seem to change my <u>main</u> objectives in life.                          | SA | A | MA | U | MD | D | SD |
| 5.  | I have discovered a satisfying life purpose.                                 | SA | A | MA | U | MD | D | SD |
| 6.  | I feel that some element which I can't quite define is missing from my life. | SA | A | MA | U | MD | D | SD |
| 7.  | The meaning of life is evident in the world around us.                       | SA | A | MA | U | MD | D | SD |
| 8.  | I think I am generally much less concerned about death than those around me. | SA | A | MA | U | MD | D | SD |
| 9.  | I feel the lack of and a need to find a real meaning and purpose in my life. | SA | A | MA | U | MD | D | SD |
| 10. | New and different things appeal to me.                                       | SA | A | MA | U | MD | D | SD |
| 11. | My accomplishments in life are largely determined by my own efforts.         | SA | A | MA | U | MD | D | SD |

	SA STRONGLY AGREE	A AGREE	MA MODERATELY AGREE	U UNDECIDED	MD MODERATELY DISAGREE	D DISAGREE	SD STRONGLY DISAGREE
12.							
I have been aware of an all powerful and consuming purpose towards which my life has been directed.	SA	A	MA	U	MD	D	SD
13.							
I try new activities or areas of interest and then these soon lose their attractiveness.	SA	A	MA	U	MD	D	SD
14.							
I would enjoy breaking loose from the routine of life.	SA	A	MA	U	MD	D	SD
15.							
Death makes little difference to me one way or another.	SA	A	MA	U	MD	D	SD
16.							
I have a philosophy of life that gives my existence significance.	SA	A	MA	U	MD	D	SD
17.							
I determine what happens in my life.	SA	A	MA	U	MD	D	SD
18.							
Basically, I am living the kind of life I want to live.	SA	A	MA	U	MD	D	SD
19.							
Concerning my freedom to make my own choice, I believe I am absolutely free to make all life choices.	SA	A	MA	U	MD	D	SD
20.							
I have experienced the feeling that while I am destined to accomplish something important, I cannot put my finger on just what it is.	SA	A	MA	U	MD	D	SD
21.							
I am restless.	SA	A	MA	U	MD	D	SD
22.							
Even though death awaits me, I am not concerned about it.	SA	A	MA	U	MD	D	SD
23.							
It is possible for me to live my life in terms of what I want to do.	SA	A	MA	U	MD	D	SD
24.							
I feel the need for adventure and "new worlds to conquer".	SA	A	MA	U	MD	D	SD
25.							
I would neither fear death nor welcome it.	SA	A	MA	U	MD	D	SD
26.							
I know where my life is going in in the future.	SA	A	MA	U	MD	D	SD



	SA STRONGLY AGREE	A AGREE	MA MODERATELY AGREE	U UNDECIDED	MD MODERATELY DISAGREE	D DISAGREE	SD STRONGLY DISAGREE
27. In thinking of my life, I see a reason for my being here.	SA	A	MA	U	MD	D	SD
28. Death is a natural, unavoidable aspect of life.	SA	A	MA	U	MD	D	SD
29. I have a framework that allows me to understand or make sense of my life.	SA	A	MA	U	MD	D	SD
30. My life is in my hands and I am in control of it.	SA	A	MA	U	MD	D	SD
31. In achieving life's goals, I have felt completely fulfilled.	SA	A	MA	U	MD	D	SD
32. Some people are very frightened of death, but I am not.	SA	A	MA	U	MD	D	SD
33. I daydream of finding a new place for my life and a new identity.	SA	A	MA	U	MD	D	SD
34. A new challenge in my life would appeal to me now.	SA	A	MA	U	MD	D	SD
35. A period of personal hardship and suffering can help give a person a better understanding of the real meaning of life.	SA	A	MA	U	MD	D	SD
36. I hope for something exciting in the future.	SA	A	MA	U	MD	D	SD

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