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Drug Usage and Interpersonal
Problem Solving Deficits

Chronic self destructive behavior can be defined as the tendency to perform behaviors that later reduce positive consequences and increase the probability of experiencing negative ones. (Kelley, Byrne, Przybyla, Eberly, Eberly, Greendlinger, Wan and Gorsky, 1985) These behaviors can be conceptualized along a continuum from indirect to very direct self-destructive behaviors.

sensation	high	self-	para-	
seeking	risk	abusive	suicide	suicide
indirect				direct

On the indirect end of the self-destructive behavior continuum lies sensation seeking behavior and high risk behavior. An interesting point about indirect self-destructive behavior was made by Faberow (1986). He says this behavior appears at all age levels but in different forms according to the activity learned. The number and kind of noncompliant behaviors increases as age increases. This suggests a predisposition to this sort of behavior.

found by Bouter, Knipschild, Feij and Volovics (1988). They tested downhill skiers on a sensation-seeking scale and found that they scored higher than non-skiers. They also found that the scores of skiers who had been injured while skiing did not differ from non-injured skiers.

On the direct behavior side of the continuum lies parasuicide and suicide. Parasuicide is defined as the person behaving as if she/he wants to kill her/himself, yet it has been found that this is not their true desire. Rather, parasuicide is an act intended to be an escape from stressful life events, especially interpersonal problems. It also elicits concern, attention and guilt from significant others as no other act is able to do. (Adam, Branchi, Hawker, Narin, Sanford & Scarr, 1978; Bancroft et al., 1979; Fieldsend & Lowenstein, 1981; Hawton, Cole, O'Grady & Osborne, 1982; Kessel, 1965; Parker, 1981; Miller, 1980) Williams, Davidson and Montgomery (1980) thought impulsive self-poisoning to be "a spontaneous reaction to stressful interpersonal circumstances. This was supported by McLeavey, Daly, O'Riordan and Taylor (1987), who found that parasuicidal people scored significantly lower on optional thinking, awareness of consequences and means-ends problem solving tests (Platt and Spivack 1977). Optional thinking being defined as when posed with a problem being able to discover, or think of, different routes of action, or options

available. Awareness of consequences being defined as being aware before performing an action what the consequences of that action might be. Means-ends being defined as, after deciding which route of action you're going to follow, to be able to follow that route to obtain the predicted outcome. All these tests deal with interpersonal type problems. As for suicide, it's place as the ultimate direct self-destructive behavior is obvious.

In the middle of these two extremes lies self-abusive behaviors. These can be classified as direct and/or indirect self-destructive behavior, a combination of high risk behavior and parasuicidal behavior. Behaviors that fall into this area are drug abuse, self mutilation and the eating disorders. The purpose of the present paper is to examine the self-destructive properties of drug abuse as related to interpersonal problem solving deficits.

According to the DSM III-R there are three diagnostic criteria for psychoactive substance abuse:

- A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following:

- (1) Continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance.
- (2) Recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated)

- B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.
- C. Never met the criteria for psychoactive substance dependence for this substance.

Page 167-168

So, drug abuse does fall under the definition of self-destructive behavior. Drug abuse is considered to be both a direct and indirect form of self-destructive behavior. For example, smoking can be seen as a direct form of self-destructive behavior because of the direct links between nicotine and cardiovascular disease. Since cardiovascular disease is the leading cause for death in the United States most smokers are

aware that their smoking might eventually kill them. So why do so many people smoke? Because smoking is also an indirect form of self-destructive behavior. Smokers don't die from cardiovascular disease until much later in life so they don't worry about it killing them until it is too late. Smokers are aware of the health risks related to nicotine use but they deny them, hoping that they will fall into the tiny percentage of people who don't die from smoking. Such individuals are characterized by the belief that, "It won't happen to me." Such denial is characterized by a refusal to see the harm they are inflicting upon themselves.

This area of self-abusive behavior is very interesting because it is here on the continuum where we start to see people with deficits in problem solving, especially those problems of a social nature. Those deficits that we will be interested in here are interpersonal problem solving skills. Problem solving can be defined as having three components: the discovering of available options, finding a means to solve the problem and being aware of the consequences of one's behavior. Research done on the relationship between interpersonal problem solving and alcoholism has constantly found strong positive correlations between problem solving deficits and increased reliance on alcohol. For instance, Patterson, Parsons, Schaeffer and Errico (1988) found that alcoholics demonstrated

interpersonal problem-solving strategies that were considerably less competent than nonalcoholics. Salzman (1981) said that with alcoholic and drug addiction "there is usually seen a narcissistic belief in invulnerability, strong denial supported by grandiose feelings of special immunity from adverse circumstances and being exempt from the consequences of one's behavior as well as the laws of nature." This inability or denial to see or accept the consequences of one's behavior is an interpersonal problem solving deficit. Penny and Robinson (1986) found adolescent smokers were significantly more external in their perceived locus of control, were lower in self esteem and higher in their levels of trait anxiety. Supporting that if they smoke to relieve stress, as indicated by the study, they would have higher anxiety levels. This compounded with their lower level of psychological resources could mean they are less able to effectively deal with interpersonal problems.

Most research done on interpersonal problem solving deficits and substance abuse has concentrated on nicotine, alcohol and heroin. There is a need to explore this relationship between interpersonal problem solving deficits and multi-drug use and abuse. My hypothesis is that there is a strong correlation between people who abuse drugs and interpersonal problem solving deficits. Also, the more drugs a person abuses the more severe their problem-solving deficits will be. In order to assess

drug abuse the McAndrew Scale (Rathus, Fox and Ortins, 1980) and a modification of the Drinking Habit Questionnaire (Cahalan, Cisin and Crossley, 1969) will be utilized. To measure interpersonal problem solving skill deficits the Measure of Interpersonal Cognitive Problem Solving (Platt and Spivack, 1977) will be used. Subjects will be sampled either from Hill House, Inc., a local drug and alcohol rehabilitation facility for teens, or Charter Hospital rehabilitation facilities. The controls will be matched in age with the drug abusing population and will include either high-school students or college freshmen.

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