Peer pressure

A convenient explanation

Why the favourite 'reason for drug use' of everyone from mum to minister is flawed

'PEER PRESSURE' is central to many drug education programmes: young people, the theory goes, take drugs because they are coerced by others. Those susceptible to this pressure are seen as lacking either the decision-making abilities to come to the 'right' decision, or the social skills to say 'No' to their peers. Behind this are two further assumptions: that the only right decision is not to take drugs; and that only deficient or inadequate people are unable to maintain this decision in the face of coercion.[1]

A companion theory says low self-esteem leads to drug use. Presumably young people take drugs to compensate for feelings of personal inadequacy or because, lacking a sense of self-worth, they are vulnerable to the judgments of others in the form of peer pressure. Both theories explain drug use in terms of the drug user's inadequacy.

These 'explanations' are convenient (see *Shifting the blame* panel), but do they explain why young people take drugs? If they are flawed, so too are some of the most popular drug education approaches in Britain today.

Logical fallacy

Much of the evidence for these theories suffers from a critical failure of logic – the mistake of assuming that when two things are found together, one must cause the other.[2] Assume, for example, that drug users usually *do* associate with other drug users. Does this mean that associating with drug users causes someone to take drugs – or does it mean the reverse, that drug use leads people to associate with other drug users? Or that neither causes the other – perhaps it's just that drugs are available in the area

> Researchers have ignored the active role of the drug user

the drug users live in? With just the evidence of a link to go on, we cannot make any statements about what causes what.

With this logical difficulty in mind, how strong is the evidence for conventional self-esteem and peer pressure theories of drug use? First, a caution: much of the available research deals with cannabis use among North American youth. The social dynamics of drug use are likely to differ when drugs occupy different social slots, from normal and approved to exceptional and illegal.

For self-esteem we can draw on a recent review of over 70 studies linking self-esteem to substance misuse which found many were flawed.[3] Often "only a very small amount" of the differences in substance misuse between people could be linked to corresponding differences in self-esteem. Other studies found no link. The authors concluded that the results were at best mixed and strongly indicated that there was *no* link between self-esteem and drug use.

by
Niall Coggans & Susan McKellar

Senior Lecturer in the Department of Pharmaceutical Sciences and Research Fellow at the Centre for Applied Social Psychology, University of Strathclyde

The ideas that peer pressure and low self-esteem cause youth drug use lie behind many drug education programmes in Britain. Such ideas divert responsibility away from the drug user and from their parents and other adults, and conform to popular views that people misuse drugs because they are inadequate. However, the evidence for these views is poor. Peer pressure could be more appropriately interpreted as peer preference and high self-esteem can also be associated with drug use. Drug education strategies need to be reviewed in the light of these insights.

Pressure or preference?

We did our own review of the literature on peer pressure. The issue was not *whether* there is a link between peer factors and illicit drug use – extensive research into young people's drug use over the past decades has shown there is – but whether 'peer pressure' is the right interpretation of this link.

'Peer pressure' suggests coercion or at least persuasion to take drugs. But the fact that drug users form groups could instead be explained by people *actively* seeking like-minded companions on the basis of shared values and beliefs, in this case, around drugs – not so much 'peer pressure' as 'peer preference'. Let's look at the evidence.

One of the major strands in research on peer pressure has been theories which try to predict what makes someone prone to problem behaviour.[4,5,6] With respect to drug use, one of the key measures assesses how strongly someone feels the influence of peers, either as role models or through their approval for drug use. A review of this work concluded that peer

influence *was* related to drug use.

However, peer influence was *also* highly related to personality measures; probably, the two were measuring the same thing.[7] It then becomes a matter of choice whether one says personality, or peer influence, is related to drug use. Without more evidence we cannot conclude that peer influence caused drug use.

Social learning approaches, the other major strand in peer pressure research, include *imitation* and the *reinforcing* effects of approval as potentially important influences on how someone learns to behave.[8,9,10] Non-drug users might imitate their drug using peer group and be rewarded by the group's approval. But these studies too have failed to come up with the results needed to support peer pressure models. Drug use *was* found to be significantly related to the attitudes of peers to drugs. However, there was no evidence that young people imitated their peers or were reinforced in their drug use by them.[11] This pattern of results is more consistent with peer preference than peer pressure.

More recent research has come up with the same pattern of results. An individual's drug use was found to be related to their peers' attitudes to marijuana as well as to their choice of friends.[12] Least important was whether friends rewarded or punished someone's marijuana use. The simplest explanation of these findings is that people who share similar attitudes, such as to drugs, gravitate together, rather than that someone's attitudes are reshaped by their friends.

Support for this interpretation comes from a study of 5000 adolescents who reported feeling free to accept or refuse offers of cannabis.[13] The conclusion was that someone who wants to take drugs is likely to seek out a drug using group.

Reasserting the individual

The relationship between a young person and their friends is likely to be one of mutual influence which changes over time. Only follow-up studies of the same people over a period of years can tease out this dynamic. One such study of marijuana use found that adolescents sharing similar attitudes and beliefs tended to form groups.[14] Having formed and reformed like-minded groups, their later use of marijuana was related to group support for this activity. However, *support* has more to do with approval than pressure, again suggesting shared attitudes and behaviours rather than the group forcing its attitudes on its members. Individual characteristics remained central to differences in drug

Combatting peer pressure was a key feature of the British Government's 1994 anti-drug campaign

A CONVENIENT EXPLANATION

The evidence for peer pressure and self-esteem explanations for drug use is weak. But the evidence that we prefer these to other, sometimes more obvious, explanations is strong. For example, one study found little direct effect of parental and peer pressures on adolescent drinking.[22] This did not discourage speculation on how parents and peers may influence adolescents. Another found substance use was strongly linked to peer drug use.[23] "Having peers who use drugs appears to be the dominant influence on whether adolescents abuse drugs," was the authors' interpretation, though others would have been equally valid.

A recent study[24] wrongly described its finding of an association between the drug use of individuals and peers as "causal effects". In another[25] the authors admitted they could not say what caused what, but the wording of their conclusions strongly implied causality. Their results, they said,"suggest that adolescent alcohol and drug use conforms to the behavioural and value structure of the peer influence group" and that their friends' drug use and tolerance of drug use are the most powerful "predictors" of someone's drug use.

The inclination to opt for peer pressure interpretations was evident in the development of a "susceptibility to peer pressure scale". In fact, this was based on measures of tolerance of deviance.[26,27]

Similarly, explanations of drug use in terms of low self-esteem appear to be preferred to alternative accounts.[28] A recent study found adolescent male smokers had *higher* self-esteem than non-smokers. The researchers reasoned that smoking boosted the boys' self-confidence, not that high self-esteem leads to drug use.[29]

1. May C. "Resistance to peer group pressure: an inadequate basis for alcohol education." *Health Education Research*: 1993, *8*(2), p.159-165.
2. Davies J.B. and Coggans N. *The facts about adolescent drug abuse*. London: Cassell, 1991.
3. Schroeder D.S. *et al*. "Is there a relationship between self-esteem and drug use? Methodological and statistical limitations of the research." *Journal of Drug Issues*: Fall 1993, p. 645-665.
4. Jessor, R. and Jessor, S.L. *Problem Behaviour and Psychosocial Development – A Longitudinal Study of Youth*. NY: Academic, 1977.
5. Jessor, R. *et al*. "A Social Psychology of Marijuana Use: Longitudinal Studies of High School and College Youth." *Journal of Personality and Social Psychology*: 1973, *26*(1), p.1-15.
6. Donovan, J.E. and Jessor, R. "Adolescent Problem Drinking – Psychosocial Correlates in a National Sample Study." *Journal of Studies in Alcohol*: 1978, *39*, p.1506-1524.
7. Kandel D.B. "Drug and drinking behaviour among youth." *Annual Review of Sociology*: 1980, *6*, p.235-285.
8. Burgess, R.L. and Akers, R.L. "A Differential Association-Reinforcement Theory of Criminal Behaviour." *Social Problems*: 1966, *14*, p.128-147.
9. Akers, R.L. *Deviant Behaviour: Social Learning Approach*. Belmont, Calif. Wadsworth, 1977.
10. Akers, R.L., *et al*. "Social Learning and Deviant Behaviour: A Specific Test of a General Theory." *American Sociological Review*: 1979, *44* (August), p.636-655.
11. Kandel D.B. op cit.
12. Akers R.L. *et al*. "Adolescent marijuana use: a test of three theories of deviant behaviour." *Deviant Behaviour*: 1985, *6*, p. 323-346.
13. Sheppard, M.A. *et al*. "Peer Pressure and Drug Use – Exploding the Myth." *Adolescence*: 1985, *20*(80), p.949-958.
14. Jessor R. and Jessor S.L. op cit.
15. Wills, T.A. and Vaughan, R. "Social Support and Substance Use in Early Adolescence." *Journal of Behavioral Medicine*: 1989, *12*(4), p.321-339.
16. Ginsberg, I.J. and Greenley, J.R. "Competing Theories of Marijuana Use: A Longitudinal Study." *Journal of Health and Social Behaviour*: 1978, *19*, p.22-34.
17. Sheppard, M.A., *et al*. "Peers or Parents: Who has the Most Influence on Cannabis Use?" *Journal of Drug Education*: 1987, *17*(2), p.123-128.
18. Coggans, N. and McKellar, S. "Drug use amongst peers: peer pressure or peer preference?" *Drugs: Education, Prevention and Policy*: 1994, *1*, p.15-26.
19. Coggans, N., *et al*. "The impact of school-based drug education." *British Journal of Addiction*: 1991, *86*, p.1099-1109.
20. Elder, J.P., *et al*. "Contingency-Based Strategies for Preventing Alcohol, Drug and Tobacco Use: Missing or Unwanted Components of Adolescent Health Promotion?" *Education and Treatment of Children*: 1987, *10*(1), p.33-47.
21. Advisory Council on the Misuse of Drugs. *Drug Education in Schools: the need for a new impetus*, HMSO, London, 1993.
22. Biddle, B.J. *et al*. "Parental and Peer Influence on Adolescents." *Social Forces*: 1980, *58*(4), p.1057-1079.
23. Bahr, S.J., *et al*. "Family and Religious Influences on Adolescent Substance Abuse." *Youth and Society*: 1993, *24*(4), p.443-465.
24. Ried, L.D. "A Path Analytic Examination of Differential Social Control Theory." *Journal of Drug Education*: 1989, *19*(2), p.139-156.
25. White, H.R. *et al*. "An Application of Three Deviance Theories to Adolescent Substance Use." *The International Journal of the Addictions*: 1986, *21*(3), p.347-366.
26. Dielman, T.E. *et al*. "Susceptibility of Peer Pressure, Self-Esteem and Health Locus of Control as Correlates of Adolescent Substance Abuse." *Health Education Quarterly*: 1987, *14*(2), p.207-221.
27. Dielman, T.E., *et al*. "A Covariance Structure Model Test of Antecedents of Adolescent Alcohol Misuse and a Prevention Effort." *Journal of Drug Education*: 1989, *19*(4), p.337-361.
28. Schroeder D.S. *et al*, op cit.
29. Currie, C. and Todd, J. *Health Behaviours of Scottish School Children: Report 1 – National and Regional Patterns. University of Edinburgh/WHO*, 1990.

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SHIFTING THE BLAME

Social psychology and the sociology of deviance have generally moved away from simplistic 'A causes B' models, but in research on drug misuse, these have persisted in the form of peer pressure and self-esteem theories. Perhaps the key to this is that such explanations fit in with the world view of those providing them. For many people, drug use is such irrational behaviour that it can only be explained in terms of the irrationality or inadequacy of the drug user, or the wickedness of others. The assumption that drug use is caused by peer pressure places the blame on others and away from the drug user. Drug users, their parents, and those responsible for the wider social, political and economic environment, can all escape the uncomfortable feeling that they too had a hand in the behaviour.

The drug user is also seen as the victim of some sort of personal inadequacy – lacking the interpersonal skills to resist coercion and/or weakened by low self-esteem. Many researchers and commentators have preferred to ignore the active role of the individual drug user, seeing them as passively reacting to the pressures put upon them.

Such explanations avoid having to come to terms with the difficult conclusion that often 'good people' take drugs *of their own free will* – that drug use can be a rational decision. Accepting this would undermine much of our drug education and prevention effort. We could no longer assume that if we enable our children to make the 'right' decisions, these will be *not* to take drugs. Most of us prefer not to accept this conclusion; feeling the foundations of your beliefs and professional activities being undermined is not a comfortable sensation.

use, whether there was high social support or not.

Another follow-up study found that young people who prefer to seek support from their peers rather than their parents were more likely to later use substances.[15] The mutual relationship between cannabis users and their peers was the central finding of a further long-term study.[16] These studies place the individual as an active force in their own life back in the frame.

Redefinition of peer pressure as peer preference raises the question of what determines which peers someone prefers. This entails assessing the influences on children *before* they form groups of like-minded peers. The foundations of delinquency, deviancy, and non-conformist behaviour – including drug use – are probably laid in these pre-peer years. In this interpretation, peer groups provide a congenial social setting for what their upbringing leads young people to want to do. Supporting this is a study which showed that parents had more influence than peers on the development of deviant behaviours prior to drug use.[17]

Educational implications

These findings and others[18] show that the evidence for peer pressure is equally – if not more – appropriately interpreted as evidence for peer preference. Clearly this has implications for drug education based on fostering resistance to peer pressure. These approaches have been largely ineffective[19] or had mixed results, though some success has been found with cigarette smoking.[20] Other studies have suggested that more broadly based life skills approaches may have some potential, though the impact is temporary.[21]

The reasons for this lack of success are simple – the underlying assumptions about how drug use happens are wrong. Most people who experiment with drugs do so for reasons that have nothing to do with psychological pathology or with an inability to resist peer pressure. Likewise, even if drug education programmes *do* develop excellent social skills, self-assertion, and high self-esteem, these will not inoculate the pupils against drug use. Drug education based on simplistic inadequacy theories is doomed to be ineffective.

That doesn't mean self-esteem or peers are irrelevant – self-image and relationships with peers *are* key factors in the development of young people across a wide range of behaviours. It does mean that we need more sophisticated and realistic models of how these affect behaviour. Individual choice and motivation have to be taken into account in drug education programmes which should also pay heed to the dynamic and reciprocal relationship between individuals and peers.

Understanding peer relationships will be vital to the increasingly prominent peer education approach. The assumption is that there is a greater empathy between the target group and their peer educators than there is with adult teachers. The effectiveness of such programmes will relate more to peer preference models than simplistic peer pressure models. ❍