Conformity Disposition and Perceived Peer Pressure: Implications for the Treatment of Drug and Alcohol Abuse Among Adolescents

by

Jean Marie Anne Raniseski

A Thesis Submitted to the Faculty of the DIVISION OF EDUCATIONAL FOUNDATIONS AND ADMINISTRATION In Partial Fulfillment of the Requirements For the Degree of MASTER OF ARTS WITH A MAJOR IN EDUCATIONAL PSYCHOLOGY In the Graduate College THE UNIVERSITY OF ARIZONA

1990
STATEMENT BY AUTHOR

This thesis has been submitted in partial fulfillment of requirements for an advanced degree at The University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this thesis are allowable without special permission, provided that accurate acknowledgment of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his or her judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: [Signature]

APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

[Signature]
L. M. Aleamoni
Professor of Educational Psychology

[Date]
Acknowledgments

Special thanks to Carol Sigelman, Ph.D. without whom this thesis would not have been written. Thank you to Lawrence Aleamoni, Ph.D. and John Obrzut, Ph.D. for their time and patience; Tucson Psychiatric Institute and Charter Hospital of Tucson for making this research possible; and caring family and friends. Additional debt and gratitude to Marie Semirale, M.S. for her constant encouragement and belief in me; and of course, the adolescents who participated in this study.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>5</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>6</td>
</tr>
<tr>
<td>Chapter 1. INTRODUCTION</td>
<td>7</td>
</tr>
<tr>
<td>Chapter 2. METHODOLOGY</td>
<td>16</td>
</tr>
<tr>
<td>Subjects</td>
<td>16</td>
</tr>
<tr>
<td>Instrumentation</td>
<td>17</td>
</tr>
<tr>
<td>Procedure</td>
<td>22</td>
</tr>
<tr>
<td>Chapter 3. RESULTS</td>
<td>24</td>
</tr>
<tr>
<td>Chapter 4. DISCUSSION</td>
<td>33</td>
</tr>
<tr>
<td>APPENDIX A: Perceived Peer Pressure Inventory</td>
<td>38</td>
</tr>
<tr>
<td>APPENDIX B: Peer Conformity Disposition Scale</td>
<td>40</td>
</tr>
<tr>
<td>APPENDIX C: Treatment Attitudes Questionnaire</td>
<td>44</td>
</tr>
<tr>
<td>APPENDIX D: Self-reported Behavior Index</td>
<td>47</td>
</tr>
<tr>
<td>APPENDIX E: Parent's Consent Form</td>
<td>48</td>
</tr>
<tr>
<td>APPENDIX F: Subject's Consent Form</td>
<td>50</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>52</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1  Mean Responses and Standard Deviations for Variables ... 24
Table 2  Correlations Between Independent Variables ............ 26
Table 3  Correlations Between Independent and Dependent Variables .............. 27
Table 4  Mean Attitude and Stigma Scores by Promisconduct Pressure and Conformity Disposition .............. 28
Table 5  Mean Attitude and Stigma Scores by Antimisconduct Pressure and Conformity Disposition .............. 30
Table 6  Mean Attitude and Stigma Scores by Proconformity Pressure and Conformity Disposition .............. 31
ABSTRACT

This study involved a sample of 40 adolescents who were inpatients at two local psychiatric facilities, receiving treatment for drug and alcohol problems. Subjects were given measures of perceived peer pressures, conformity dispositions (willingness to conform to peer pressure), misconduct, attitudes toward treatment, and sense of stigma associated with being in treatment. Perceived peer pressure was significantly related to self-reported misconduct, conformity disposition and proconformity pressure were significantly related to attitudes toward treatment, and the interaction between perceived peer pressure and conformity disposition was significantly related to sense of stigma associated with being in treatment. The findings reveal a complexity in the treatment of adolescent drug and alcohol problems, and warrant further investigation.
Adolescent drug and alcohol abuse is an expansive problem in today's society, and extremely difficult to treat. Researchers know that peer influence plays an important role in the problem (Alexander & Campbell, 1965; Burkett, 1977; Burkett & Jensen, 1975; Forslund & Gustafson, 1969; Halebsky, 1987; Kandel, Kessler, & Margulies, 1978; Reid, Marinson, & Weaver, 1987; Riester & Zucker, 1968; Snyder, Dishion, & Patterson, 1986; Stone, Miranne, & Ellis, 1979; Tec, 1972; Wechsler & Thum, 1973). The purpose of this study is to identify the role that peer influence or peer pressure plays in adolescents' recovery from drug and alcohol problems, and more specifically, what influence peers have over adolescents' attitudes toward treatment, and sense of stigma associated with being in treatment.

Clasen and Brown (1985) define "peer pressure" as "conformity demands from peers" (p.457) and "pressure to think or behave along certain peer prescribed guidelines" (p.452). Researchers assume that peers play an influential role in adolescent development, and that peer pressure is an important component of this role. Until Brown (1982), few studies had investigated the true extent of peer pressure's influence. Brown initiated a retrospective study involving 297 college undergraduates in order to assess the types of peer pressures adolescents experienced and how influential these peer pressures were. According to Brown's (1982) results, one third of both males and females reported that peer pressure was one of the most difficult parts of being
an adolescent. In general, it was found that females experienced greater amounts of peer pressure than males did; however, it was in different areas. Females were more influenced in the areas of dress and grooming styles, dating, social involvement, and cigarette smoking, while males experienced greater pressure in areas such as use of drugs and alcohol and sexual intercourse.

According to Brown (1982), peer pressure becomes the price of group membership. Peer pressure can be positive, meaning pressure to think and behave in ways that adults value (e.g., pressure to value the importance of school and family). It can also be negative, meaning pressure to think and behave in ways that adults devalue (e.g., pressure to engage in vandalism, use drugs and alcohol, etc.).

Clasen and Brown (1985) further investigated the types of peer pressure experienced by adolescents and the variable influence these pressures have over them. In order to do this, Clasen and Brown developed the Peer Pressure Inventory. This measure consisted of 53 questions concerning the five areas of peer pressure reported retrospectively by a pilot sample of 297 undergraduates, age 18-22, enrolled in developmental psychology classes at a large midwestern university. The five areas were: peer involvement (attending social functions, spending free time with friends, dating, etc.), involvement in school (academic and extracurricular activities), involvement with family, conformity to peer norms (in dress, grooming, musical tastes, etc.), and misconduct (sexual intercourse, delinquent behaviors, and the use of drugs and alcohol).
As predicted by Clasen and Brown, there were differences in direction and degree of peer pressures perceived by respondents in the five pressure areas. Adolescents reported a decrease in pressure to conform to peer norms and an increase in pressure to participate in misconduct across grades. Crowd comparisons showed "druggie-toughs", those currently involved in drug or alcohol using peer groups, reporting the highest degree of pressure toward misconduct; "jock-populars", those currently involved in athletic and popular peer groups, reporting the lowest pressure toward misconduct; and "loners", those not currently involved in any peer groups, varying across communities (rural vs. urban). These results support the view that peer pressure is a multidimensional force which varies in strength and direction across grades, between peer cliques, and in different areas of adolescent life.

Clasen and Brown (1985) also found that as pressure toward peer involvement increased, pressure toward family or school involvement decreased. This has been reported by several other researchers as well (Condry & Siman, 1974; Forslund & Gustafson, 1969; Glynn, 1981; Halebsky, 1987; Huba, Wingard, & Bentler, 1979; Stone, Miranne, & Ellis, 1979).

In order to better understand adolescent development, we must also consider conformity disposition or willingness to conform. The influence peers have over adolescents may result more from willingness to conform to group norms and attitudes than from actual peer pressure, and adolescents will vary in their susceptibility to peer pressure. Erikson (1968) argued that adolescents have a need for group affiliation
in order to facilitate proper development; thus, they conform to the group's norms so that they will "fit in" or belong. Adolescents' peer conformity disposition has been described as following an inverted-U shaped pattern with development, meaning that peer conformity disposition increases from childhood to early or middle adolescence, then declines in late adolescence (Asch, 1951; Berndt, 1979; Costanzo & Shaw, 1966; Iscoe, Williams, & Harvey, 1963).

Brown, Clasen, and Eicher (1986) incorporated the idea of peer conformity disposition in their study of perceived peer pressure in the areas of peer involvement and misconduct, and its relationship to self-reported behavior. It was their belief that developmental changes in peer conformity were "mediated by the strength of peer conformity disposition and the nature of the conformity demands from peers (peer pressure)" (p.522). The purpose of their study was to investigate how variations in peer conformity disposition and perceived peer pressure corresponded with variations in self-reported behavior—more specifically, levels of misbehavior—and the effects of gender and age on this relationship.

Brown et al. (1986) found significant relationships between perceived peer pressure and self-reported behavior, peer conformity disposition and self-reported behavior, and the interaction between perceived peer pressure and peer conformity disposition and self-reported behavior. There was a stronger relationship between perceived peer pressure and peer conformity disposition and misconduct than between these variables and peer involvement behaviors, meaning
that perceived peer pressure and peer conformity disposition were better predictors of antisocial behavior than they were of prosocial behavior. In addition, in the area of misconduct and antisocial behavior, perceived peer pressure and peer conformity disposition appeared to be mutually reinforcing. The higher the willingness to conform to antisocial peer pressure, the stronger the relationship between perceived peer pressure and self-reported misconduct. Neither gender nor age had any significant effect on the relationship between perceived peer pressure, peer conformity disposition, and self-reported behavior.

Researchers have argued and found that peers initiate adolescents into drug and alcohol use and delinquent behavior. Alexander and Campbell (1965) found that the greater the number of drinking friends adolescents have, the more likely they are to drink. Burkett (1977) reported a similar result regarding marijuana use among adolescents; those adolescents who associated with peers who are involved in marijuana use are more likely to use marijuana as well. Burkett (1977) also found that adolescents involved in drug use are more likely to engage in delinquent behavior. Other researchers have found similar trends in peer influence on drug and alcohol use (Biddle, Bank, & Marlin, 1979; Burkett & Jensen, 1975; Forslund & Gustafson, 1970; Glynn, 1981). The findings of Brown, Clasen, and Eicher (1986) further support this theory, and also suggest that the combination of a disposition to conform and strong negative peer pressure is particularly likely to result in delinquent behavior. They also indicate that peers influence adolescents' involvement in misconduct more than their participation in
peer social activities.

Knowing that peers have this influence over adolescents' initiation into misconduct, and more specifically drug and alcohol use, it is important to look at whether peers also influence recovery from drug and alcohol problems. Adolescents admitted to a drug and alcohol treatment facility do not necessarily leave their peer conformity disposition and perceived peer pressure behind them; they bring them into the treatment setting with them. If this is the case, by understanding adolescents' perceived peer pressures and level of peer conformity disposition, a treatment team might be able to predict adolescents' attitudes toward being in treatment and any possible stigma they perceive to be associated with receiving help for their problem. Assessing adolescents' attitudes toward treatment is an important part of therapy. Adolescents must want to be there, believe that therapy will help them, and be willing to work on their problems in order to resolve them (Taylor, Adelman, & Kaser-Boyd, 1984).

Adolescents involved in delinquent peer groups tend to resist treatment as a form of rebellion against authority (Miller & Burt, 1982; Muuss, 1982). Often adolescents are referred to treatment and resent the third party interference; as a result, they have no commitment to or motivation for treatment (J. Brehm, 1972; S. Brehm, 1976). In addition, many adolescents have negative perceptions of therapy, often based on previous experiences (Taylor et al., 1984). It is important to recognize such problems in order to facilitate treatment.

Like harboring negative attitudes toward treatment, associating a
sense of stigma with being in therapy (feeling embarrassed or ashamed) may also interfere with recovery. There is a stigma attached to having psychological problems according to Farina, Holland, and Ring, (1966), Farina and Ring, (1965), and Farina, Allen, and Saul, (1968). If adolescents fear that others, especially peers, will treat them differently if they enter therapy, they may choose to avoid it or rush the process in order to be discharged early.

It is believed by this investigator that perceived peer pressure, peer conformity disposition, and history of deviant behavior all play a critical role in the recovery process from drug and alcohol abuse. These forces influence adolescents' attitudes toward treatment, and contribute to the perception of a stigma associated with receiving help. As mentioned earlier, adolescents involved in delinquent peer groups approach therapy with negative attitudes. They view treatment as an inconvenience or a disruption of their normal activities, but they do not necessarily view it as something to be ashamed of or stigmatized for. Admission into treatment for a drug and alcohol problem is seen as an invasion of adults into the adolescents' world. Being able to resist any help or treatment from adults might actually raise their standing in the peer group, so they might actually brag about being in treatment rather than being ashamed of it. On the other hand, adolescents who were involved in a more prosocial type of peer group (one that does not encourage misconduct) would probably have more positive attitudes toward treatment. They would realize that they had a problem and be more anxious to work through it. These adolescents, however, might associate
a sense of stigma with receiving help since their peers were not as involved in, or supportive of, the type of behavior for which they were being treated.

Based on these assumptions, the following hypotheses were formed:

1. A strong peer conformity disposition and peer pressure toward misconduct will be associated with a negative attitude toward treatment, and little or no perceived stigma associated with being in treatment. These factors will have both independent and interactive effects on attitude toward treatment and perceived stigma.

2. A strong conformity disposition and peer pressure away from misconduct will be associated with a positive attitude toward treatment and a perceived stigma attached to it.

3. A weak conformity disposition and peer pressure toward or away from misconduct will be associated with moderate attitudes toward treatment and moderate levels of perceived stigma. Peer pressure will still have some effect, but the effect will be muted when susceptibility to peer influence is low.

4. Peer conformity disposition and perceived peer pressure will be independently related to self-reported misconduct (meaning peer conformity disposition will be related to self-reported misconduct and perceived peer pressure will be related to self-reported misconduct) and interactively related to self-reported misconduct (meaning that the interaction term of conformity disposition and perceived peer pressure will be related to self-reported misconduct.
misconduct) in a drug and alcohol abusing sample, as Brown, Clasen, and Eicher (1986) found them to be in a normal sample of adolescents.

5. The more frequent the adolescent's self-reported misconduct before entering treatment, the more likely it is that the adolescent will have a negative attitude toward treatment and a low sense of stigmatization. This hypothesis is based on the assumption that extent of misconduct indicates extent of involvement in an antisocial peer culture.
CHAPTER 2

METHOD

Subject

The sample consisted of 40 adolescents who were admitted to the drug and alcohol rehabilitation program at either the Tucson Psychiatric Institute or Charter Hospital of Tucson. These adolescents ranged in age from 13 to 17 years old, with a mean age of 15, and were in grades 8 to 13, with the majority being in the eighth and ninth grades. There were 21 females and 19 males, representing eight Hispanics, two Blacks, one Asian and 29 Anglos. Five adolescents sought as participants did not participate due to their or their parents' refusal or an early discharge date.

Access was gained to this population through the investigator's employment at the Tucson Psychiatric Institute and Charter Hospital of Tucson, and through approval from each administrator and program director. The investigator was the only person collecting data due to confidentiality policies in both hospitals.

Both the Tucson Psychiatric Institute and Charter Hospital of Tucson provide a highly structured, supportive, and educational environment for the adolescents. Treatment involves patients and their families. Patients participate in individual as well as group therapies. Treatment teams involve psychiatrists, psychologists, nurses, social workers, occupational therapists, activity therapists, mental health technicians, teachers and nutritionists. Due to the similarity of the programs, subjects were drawn from both facilities,
and their data combined.

Instrumentation

The study involved the measurement of five constructs: perceived peer pressure, conformity disposition, self-reported behavior, attitudes toward treatment, and sense of stigma in treatment.

Subscales of the Peer Pressure Inventory (Clasen & Brown, 1985) were used to measure the amount of peer pressure subjects perceived in the areas of pro peer conformity pressure (pressure to adhere to norms designated by peers), promisconduct pressure (pressure to become involved in delinquent activities), and antimisconduct pressure (pressure to not become involved in delinquent activities). The other five subscales were eliminated due to their length and irrelevance to this study.

The Pro Peer Conformity Pressure subscale consisted of eight questions, asking about perceived pressure to conform to peer norms, such as listening to the same type of music one's friends do, acting and dressing the way one's friends do, etc. This subscale had a coefficient alpha of 0.83 in the Clasen and Brown (1985) study and a coefficient alpha of 0.88 in this study. Promisconduct Pressure was measured by ten questions related to involvement in delinquent activities (misconduct)—for example, smoking cigarettes, drinking, and shoplifting. The coefficient alpha is 0.84 (Clasen & Brown, 1985), and 0.85 in this study. Finally, the Antimisconduct subscale, with a coefficient alpha of 0.84 (Clasen & Brown, 1985), originally consisted of ten questions measuring peer pressure not to become involved in
delinquent activities, and was shortened to nine questions with an alpha of 0.68 after completing an internal consistency analysis and attempting to optimize internal consistency. Examples include pressure not to smoke, not to drink, and not to shoplift.

The response format for all of the peer pressure items was a four-point Likert scale (Strong Pressure, Some Pressure, Very Little Pressure, and No Pressure). Subjects were asked to report the amount of peer pressure they perceived for each item. A score was then calculated for each subscale. Items were recoded so that all were scored with the highest value assigned to potentially negative peer pressures (that is, pressure toward conformity and misconduct and lack of pressure away from misconduct). Scores for each subscale represented the mean of the item responses and ranged from 4.00 (strong negative pressure) to 1.00 (strong positive pressures). (see Appendix A).

The Peer Conformity Disposition Scale, originally developed by Berndt (1979) and revised by Brown et al. (1986), was further revised for purposes of this study. Brown et al. (1986) shortened Berndt's (1979) original questionnaire from 30 to 20 hypothetical situations. Ten questions were eliminated due to their suspected outdatedness. Brown et al. (1986) also reworded the remaining 20 questions to make them more clear and more relevant to today's adolescents. For purposes of this study, only 15 of the revised situations were used because they pertained to neutral and antisocial situations. The other five questions were eliminated because they involved prosocial situations, which were not being investigated in this study. In addition, the
response format was altered from a six-point Likert scale to a five-point Likert scale in order to clarify the response options and make it easier for the adolescents to understand.

Subjects were presented with 15 hypothetical situations and asked what they would "really do". Eight of the situations were considered antisocial and involved behaviors such as stealing, cheating, and vandalism. Peers suggested a behavior that the subjects were supposedly reluctant to perform, and subjects had to decide what they would do. For example, "You go with a couple of your best friends on Halloween. They're going to soap windows, but you're not sure whether you should or not. Your friends all say you should because there's no way you would get caught." Subjects are provided with either a positive or a negative response (Soap the windows or Not soap the windows), depending on the item, and asked to indicate on a five-point Likert scale whether they would or would not display that response (Definitely Not, Probably Not, Unsure, Probably, Definitely). Brown et al. (1986) reported a coefficient alpha of 0.63 for their antisocial subscale. After analyzing adolescents' responses, three questions were eliminated due to their inconsistency with other responses, leaving a five-item scale with a coefficient alpha of 0.82. Adolescents seemed to be confused by the fact that the three items omitted involved a reversal of the response to peers to be evaluated.

The remaining seven situations were responded to in this same manner, and included neutral items pertaining to choices of hobbies, entertainment, and sports. Peers would encourage subjects to join them
in one activity while they were interested in doing another; for example, peers might ask the subject to get together with them, but the subject wants to watch television at home. Brown et al. (1986) reported a coefficient alpha of 0.83 for this scale, but this study revealed only a 0.63 coefficient alpha for this scale. Thus it was not used in further analyses.

Scores were calculated for the antisocial and neutral conformity disposition subscales by averaging scale item scores. Items were recoded as necessary in order to assign a high value to conforming responses. Scores ranged from 4.00 (conforming) to 0.00 (non-conforming), with 2.00 being the neutral point (see Appendix B).

The measure used to assess adolescents' attitudes toward treatment was a modification of the Psychiatric Attitudes Questionnaire from the Psychiatric Attitudes Battery-Multiple Choice Attitude Test (Reznikoff, Brady & Zeller, 1959). It originally consisted of twelve questions, but only eleven were used in this study. One was eliminated due to its irrelevance to this study. The eleven that were used were revised slightly, using the phrases "drug and alcohol problems" or "drug and alcohol treatment center" instead of "psychiatric problems" and "psychiatric hospital" in order to make items more relevant to the study. The questions focused on the subjects' overall attitude regarding the treatment of drug and alcohol problems, and required a positive, neutral, or negative response. For example, "The care a patient receives in a drug and alcohol treatment center is likely to be: Good, Fair or Poor." No reliability was established by Reznikoff et al.
The coefficient alpha for this sample was 0.86. Some items were recoded so that 1 always indicated a positive attitude, 2 a neutral attitude and 3 a negative attitude toward treatment (see Appendix C, #1-11).

The measure of stigma associated with treatment consisted of five questions taken directly from the stigma subscale of the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970), which had a coefficient alpha of 0.70. Four additional questions were created by this researcher using Fischer and Turner (1970) as a guide. The nine questions established whether or not subjects perceived a stigma associated with receiving treatment for a drug or alcohol problem and required agreement or disagreement with each statement. For example, "It would be all right if others found out that I was a patient in a drug and alcohol treatment center: Agree Strongly, Agree, Disagree, Disagree Strongly." A total stigma score was calculated by averaging the scale item responses. The response scale was originally Agree Strongly = 4, Agree = 3, Disagree = 2, Disagree Strongly = 1. Once again, some items were recoded so that high values always indicated a high sense of stigma and total stigma score ranged from 1 to 4. With the omission of one item that was not truly related to the stigma associated with treatment (Having had a problem with drugs and alcohol carries with it a lot of shame), the coefficient alpha for the resulting eight-item scale was 0.83 (see Appendix C, #12-20).

The final measure utilized was an adaption of the Misconduct Subscale of the Self-Reported Behavior Index (Brown et al, 1986). This
measure was used to gain a better understanding of adolescents' behavior before they entered treatment, and to test hypotheses about the relationships of peer pressure and conformity disposition to antisocial conduct. There were eleven activities and in this study subjects were asked to report "how many days in the past month" they had participated in each act. For example, "How many days in the past month have you gotten drunk?" Responses ranged from 0.00 (not at all that month) to 31.00 (every day that month). High scores (large number of days) represented a high level of misconduct, while low scores (low number of days) represented a low level of misconduct. A total score was calculated by averaging across all eleven items. The coefficient alpha for this measure was 0.89 in this study (see Appendix D).

Procedure

Within one week of an adolescent's admission, parents or guardians were contacted by telephone or in person at the hospitals to gain their written consent (see Appendix E). Once permission was granted, adolescents were asked to sign a consent form (see Appendix F). Both parents and adolescents were told that the questionnaires would be anonymous, that participation was voluntary, and that refusal to participate would not interfere with their treatment in any way.

Upon obtaining written consent, adolescents were asked to complete the battery of questionnaires described above. Adolescents were given a brief oral explanation of the response format for each questionnaire and were given approximately 24 hours to complete the battery. This time frame was allotted due to the adolescents' highly structured day and
lack of free time. Given 24 hours, the adolescents could successfully complete the battery without it interfering with scheduled activities, which was a guarantee given to the parents and the program directors.
CHAPTER 3

RESULTS

Table 1 presents the mean score and standard deviation for each of the independent variables (pro peer conformity, promisconduct, and antimisconduct peer pressure; antisocial conformity disposition; and self-reported behavior) and the dependent variables (attitude toward treatment and sense of stigma). Overall, adolescents involved in this study reported between very little and some peer pressure toward misconduct and peer conformity, and somewhat more pressure away from misconduct. They scored in the middle of the range for antisocial conformity disposition (neither high nor low). Self-reported deviant behavior averaged about nine times a month across the eleven items.
inquired about. However, the large standard deviation indicates that there was considerable variation in how much misconduct the adolescents in the study were actually involved in. Since these were adolescents being treated for drug and alcohol problems, it is no surprise that the highest number of occurrences were in these areas. The least frequently occurring behaviors were shoplifting and vandalism. The overall mean for adolescents' sense of stigma was moderate (2.22) where 4.00 is the maximum.

Due to the small number of subjects (N=40), and the lack of a significant effect of gender on responses, all subjects were lumped together for the following analyses.

Correlations between the independent variables are presented in Table 2. Proconformity pressure and conformity disposition were positively correlated (r=.50), as were promisconduct pressure and conformity disposition (r=.50). The products of each of these pressure variables and conformity disposition were even more highly correlated with their constituents. Therefore, it was not possible to conduct a multiple regression analysis including these variables and product terms representing the interaction between them as predictors. It is important to note, however, that peer pressure and conformity disposition are positively correlated, as expected.

Conformity disposition was not significantly correlated with antimisconduct pressure, and antimisconduct pressure was negatively related to proconformity pressure, indicating that those who experienced strong antimisconduct pressure also experienced strong pressure to
Table 2

Correlations Between Independent Variables

<table>
<thead>
<tr>
<th></th>
<th>Procon</th>
<th>Promis</th>
<th>Antimis</th>
<th>Conf</th>
<th>SRB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proconformity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promisconduct</td>
<td>.51**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antimisconduct</td>
<td>-.35***</td>
<td>-.09</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conformity Disposition</td>
<td>.50***</td>
<td>.50***</td>
<td>.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Reported Misconduct</td>
<td>.30*</td>
<td>.37**</td>
<td>-.14</td>
<td>.11</td>
<td></td>
</tr>
</tbody>
</table>

*p<.05  **p<.01  ***p<.001

conform to the group; however, antimisconduct pressure was unrelated to promisconduct pressure. This unexpected result raises questions about whether respondents understood the antimisconduct pressure items.

Moreover, both high proconformity pressure and high misconduct pressure were, as expected, associated with a high rate of self-reported misconduct.

Table 3 presents the correlations between the independent variables and dependent variables; and between the dependent variables. Attitudes toward treatment were significantly correlated with proconformity pressure and conformity disposition; (r=.31 and r=.33 respectively). The adolescents with the most negative attitudes toward treatment are those most predisposed to conform to peers who report pressure to do things with their peers.
Table 3
Correlations Between Independent and Dependent Variables

<table>
<thead>
<tr>
<th>Independent</th>
<th>Attitudes</th>
<th>Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proconformity</td>
<td>.31*</td>
<td>.35*</td>
</tr>
<tr>
<td>Promisconduct</td>
<td>.21</td>
<td>-.02</td>
</tr>
<tr>
<td>Antimisconduct</td>
<td>-.03</td>
<td>-.19</td>
</tr>
<tr>
<td>Conformity Disposition</td>
<td>.33*</td>
<td>.25</td>
</tr>
<tr>
<td>Self-Reported Misconduct</td>
<td>.12</td>
<td>.13</td>
</tr>
<tr>
<td>Stigma</td>
<td>.30*</td>
<td></td>
</tr>
</tbody>
</table>

*p<.05

Sense of stigma was most closely correlated with strong conformity pressure (r=.35). While high conformity disposition was also associated with more felt stigma, the correlation fell short of significance (r=.25).

Attitudes toward treatment and sense of stigma were significantly correlated (r=.30); however, it was a modest relationship. Promisconduct pressure tended to be positively associated with negative attitudes toward treatment, but negatively associated with felt stigma. Though both r's fell short of significance, they were in the predicted direction. However, pressure toward peer involvement was positively and
significantly related to both negative attitudes toward treatment and felt stigma.

Median splits were done on the peer pressure and conformity disposition measures so that interactions between peer pressure and conformity disposition could be examined more fully. Hypothesis 1 was assessed by promisconduct conformity disposition two-way analyses of variance (ANOVA) on attitude and stigma scores (see Table 4).

<table>
<thead>
<tr>
<th>Conformity Disposition</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Promisconduct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>1.35</td>
<td>1.39</td>
</tr>
<tr>
<td>High</td>
<td>1.78</td>
<td>1.69</td>
</tr>
<tr>
<td>Attitudes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.99</td>
<td>2.30</td>
</tr>
<tr>
<td>Stigma</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.47</td>
<td>2.24</td>
</tr>
</tbody>
</table>

There was a significant main effect of conformity disposition on attitudes, $F(1,36)=10.37$, $p < 0.05$, indicating that when conformity disposition was high, attitudes toward treatment were more negative than when conformity disposition was weak. The mean for high conformers was 1.73 and the mean for low conformers was 1.36 on a scale of 0.00 to 4.00. The main effect of promisconduct pressure and the interaction between promisconduct pressure and conformity disposition were not significant. For the stigma measure, there were no significant main
effects or interactions of promisconduct pressure and conformity disposition.

In summary, with respect to Hypothesis 1, conformity disposition seemed to be the only significant factor associated with adolescents' attitudes toward treatment. If conformity disposition was strong, attitudes were more negative than if conformity disposition was weak. Although the effect of promisconduct pressure on adolescents' attitudes was not significant it was closely correlated with conformity disposition and must still be considered when studying adolescents' attitudes toward treatment.

Hypothesis 2 was tested by an ANOVA investigating the relationship between antimisconduct peer pressure and conformity disposition, and attitudes and stigma (see Table 5). There was a significant main effect of conformity disposition on attitudes, $F(1,36)=10.66$, $p<0.01$, meaning once again that when conformity disposition was strong, attitudes toward treatment were more negative than when conformity disposition was weak. The main effect of antimisconduct pressure and the interaction between antimisconduct pressure and conformity disposition were nonsignificant for attitudes. There was, however, a main effect of antimisconduct pressure on stigma, $F(1,36)=4.15$, $p<0.05$. The more antimisconduct pressure adolescents perceived, the greater the stigma they attached to receiving treatment. Adolescents experiencing strong antimisconduct pressure had a mean of 2.41, while adolescents experiencing little anti-misconduct pressure had a mean of 2.05 on a scale of 1.00 to 4.00. The main effect of conformity disposition and the interaction between
antimisconduct pressure and conformity disposition were nonsignificant.

### Table 5

<table>
<thead>
<tr>
<th>Conformity Disposition</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Antimisconduct Pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weak</td>
<td>Strong</td>
</tr>
<tr>
<td>Attitudes</td>
<td>1.30</td>
<td>1.43</td>
</tr>
<tr>
<td>Stigma</td>
<td>2.01</td>
<td>2.21</td>
</tr>
</tbody>
</table>

Hypothesis 3 was generally not supported, as indicated by the first two ANOVAs discussed. A weak conformity disposition was associated with less negative attitudes toward treatment and lower perceptions of stigma than was a high conformity disposition. However, the amount of peer pressure perceived by the adolescent was no more influential when conformity disposition was strong than when it was weak.

A third ANOVA was performed using pro peer conformity pressure and conformity disposition as the independent variables (see Table 6). There was again the same significant main effect of conformity disposition on attitudes, $F(1,36)=6.21$, $p<0.05$; along with a significant main effect of proconformity pressure $F(1,36)=5.36$, $p<0.01$. The interaction between proconformity pressure and conformity disposition were nonsignificant. The main effect of proconformity pressure on
stigma was significant, $F(1,36)=4.34$, $p<0.05$, meaning that those 

<table>
<thead>
<tr>
<th>Conformity Disposition</th>
<th>Proconformity</th>
<th>Proconformity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Attitudes</td>
<td>1.39</td>
<td>1.27</td>
</tr>
<tr>
<td>Stigma</td>
<td>2.11</td>
<td>2.13</td>
</tr>
</tbody>
</table>

adolescents who perceived high pressure to conform to peer norms perceived a greater stigma associated with being in treatment than those adolescents who perceived low proconformity pressure. The main effect of conformity disposition was not significant, but the interaction between proconformity pressure and conformity disposition was significant, $F(1,36)=4.15$, $p<0.05$. This means that as both proconformity pressure and conformity disposition increased, so did the perception of a stigma associated with treatment for drug and alcohol abuse. The pattern of means indicates that the effect of proconformity pressure is not evident among adolescents with a low conformity disposition, but that among those with a high conformity disposition, stigma is more likely to be felt by adolescents who experience strong conformity pressure than by those who experience low conformity pressure.
Hypothesis 4 was only partially supported in this study. As Table 2 revealed, promisconduct pressure and proconformity pressure, though not antimisconduct pressure, were correlated with self-reported misconduct ($r = .37$ and $r = .30$, respectively). Conformity disposition and self-reported misconduct were unrelated ($r = .11$). The multiplicative interaction between promisconduct pressure and conformity disposition and the interaction between proconformity pressure and conformity disposition were also unrelated to self-reported misconduct. The correlation coefficients were less than .22.

Hypothesis 5 was also not supported in this study. Self-reported behavior only minimally correlated with attitudes and stigma ($r = .12$ and $r = .13$, respectively). Past misbehavior is therefore not a good indicator of adolescents' attitude toward treatment and sense of stigma regarding treatment for drug and alcohol abuse.
CHAPTER 4
DISCUSSION

The purpose of this study was to investigate the relationships between adolescents' perceived peer pressures (proconformity peer pressure, promisconduct peer pressure, and antimisconduct peer pressure), conformity disposition (willingness to conform to peers and to engage in antisocial behaviors), self-reported misconduct, and both attitudes toward treatment and perceived stigma associated with treatment. Initial hypotheses regarding these relationships were only partially supported.

Hypothesis 4, derived from the Brown et al. (1986) finding that perceived peer pressure and conformity disposition are significantly related to self-reported behavior, both independently and interactively, was supported only in part. Perceived peer pressure and conformity disposition were significantly correlated with each other, promisconduct peer pressure was related to self-reported deviant behavior, and proconformity peer pressure was also related to self-reported behavior, but conformity disposition was not related to self-reported behavior independently, nor did it interact with perceived peer pressure to affect behavior. It is likely that adolescents involved with delinquent peer groups are pressured by their peers to conform to peer norms that encourage misconduct, thus reporting higher incidences of misconduct.

Conformity disposition was significantly related to adolescents' attitudes toward treatment, regardless of the type or strength of perceived peer pressure reported by the adolescents. The stronger the
conformity disposition, the more negative were the attitudes toward treatment. Only pro peer conformity peer pressure was significantly related to attitudes toward treatment; however, the strength of promisconduct pressure may have indirectly been related to adolescents' attitudes. As the perception of peer pressure in the areas of proconformity and promisconduct increased, so did the strength of the conformity disposition, and increased conformity disposition was associated with an increase in negative attitudes toward treatment. This does not suggest a causal relationship; however, it does suggest that these two independent variables are interrelated and might both be considered when investigating adolescents' attitudes toward treatment. Strong conformers must have something to conform to, and a perception of strong peer pressure to conform to antisocial peer norms provides this.

Sense of stigma was related to an interaction between proconformity peer pressure and conformity disposition. This suggests that adolescents who are more likely to conform to peer pressures, and who perceive strong pressure from their peers to conform to the norms of the group, are more likely to associate a sense of stigma with receiving treatment. In addition, strong antimiisconduct pressure was significantly correlated with adolescents' sense of stigma, meaning that those adolescents who felt the strongest pressure to avoid delinquent behaviors (the low scorers) felt more stigmatized by having been admitted to a drug and alcohol treatment facility. In sum, those adolescents who perceive pressure to behave according to peer prescribed norms of avoiding misconduct, and who are strong conformers, feel a
sense of stigma or shame in admitting that they have a problem with drugs and alcohol and need help. They may fear that since their behavior did not follow the prescribed guidelines of their peer group, their peers will think less of them.

Initially, in hypotheses 1 and 2, the relationship between attitudes and sense of stigma was expected to be negative, meaning that adolescents with negative attitudes toward treatment would not associate a sense of stigma with the treatment, and adolescents with positive attitudes toward treatment would associate a stigma with receiving treatment. In this study, however, negative attitudes toward treatment and sense of stigma were positively correlated. Adolescents who were predisposed to conform and perceived high proconformity pressure or strong antimisconduct pressure reported a sense of stigma. Negative attitudes toward treatment may stem from the fact that most adolescents do not want to be in treatment for their drug and alcohol problems. They resent the interference of adults in their lives, want to avoid contact with authority figures, or have had negative experiences with therapy in the past. In addition, adolescents who were likely to go along with the crowd were especially negative toward treatment, maybe because they fear peer rejection when they are caught and sent to treatment.

Results from this study must be interpreted cautiously. The population used in this investigation was much different from the population used in the Brown et al. (1986) study. The measures utilized were not validated for adolescents being treated for drug and alcohol
problems on an inpatient basis at psychiatric facilities. In addition, the sample size was very small, resulting in possibly inaccurate findings regarding such a population. This study provides information for further investigations, but does not provide any conclusive evidence about the relationships between perceived peer pressure, conformity disposition, self-reported behavior, attitudes toward treatment, and sense of stigma.

The low reliability of the antimisconduct pressure scale posed further problems for this study. It appears as though the adolescents had a difficult time understanding and responding to the items in this scale because they asked about pressure not to engage in acts. In addition, the antimisconduct pressure scale should have correlated negatively with the promisconduct pressure scale, since antimisconduct pressure should be weak when promisconduct pressure is strong. The fact that these measures were not correlated casts doubt on the accuracy of analyses involving the antimisconduct scale.

Allowing 24 hours for completion of the battery of questionnaires may have posed additional problems for this study. If the schedule had allowed it, completion of the questionnaire in one sitting would have been optimal. This way the investigator would have been able to monitor the testing and to ensure that the answers were based on the individual's own effort rather than a possible group collaboration. In addition, answers might have been more consistent if the questionnaires had been completed in their entirety in one sitting rather than in pieces throughout the day.
Overall, the basic finding of this study was that peers matter in the treatment of adolescents with substance abuse problems. Adolescents who are likely to conform to peer pressures or who perceive pressure to conform to peers are not happy about being removed from their group and placed in treatment. Peers do not put adolescents into treatment, adults do. This may increase resistance to the treatment and foster negative attitudes about the treatment process as a whole. Stigma may be associated with treatment if adolescents perceive that peers will look down upon them or think less of them because they are receiving help. Further research should continue to focus on the relationships between perceived peer pressure, conformity disposition, self-reported misbehavior, attitudes toward treatment, and sense of stigma associated with treatment. Validation of the measures with clinic and hospital populations should be done, and efforts should be made to improve on the antimisconduct scale developed by Clasen and Brown (1985).

Psychological teams must take adolescents' attitudes toward treatment and perceptions that it is stigmatizing to be in treatment into account if they want to facilitate the treatment process. Time must be spent teaching adolescents what psychological treatment is all about, and convincing them that it can be a positive experience. Perhaps adolescents would then approach treatment for their problems in a positive way, would be supported by their peers for receiving help, and would not associate a stigma with treatment.
Here are some questions about peer pressure. "PEER PRESSURE" is encouragement you feel from your friends. They may want you to do something and try to talk you into it. Or maybe they DON'T want you to do something and so they encourage you NOT to do it.

Sometimes you feel pressure without your friends saying anything. Like when all your friends have new clothes, or go somewhere, or do something. You feel pressure to buy clothes, to go along, or do whatever they do. Even if no one says anything to you.

Tell me HOW STRONG the pressure is from YOUR FRIENDS to do each of the following things.

Circle ONE number for EACH question.

<table>
<thead>
<tr>
<th>How strong is the pressure from your friends to:</th>
<th>Strong</th>
<th>Some</th>
<th>Very Little</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Listen to the kind of music (groups, individuals) your friends like?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2. NOT smoke cigarettes?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3. Be tough, pick fights, etc.?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>4. &quot;Trash&quot; things (vandalize property)?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>5. NOT drink beer or hard liquor?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6. Do the same things that your friends like to do?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>7. Do hard drugs?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>8. Think about people the same way your friends do?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>9. Go &quot;all the way&quot; (have sexual intercourse)?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Question</td>
<td>STRONG PRESSURE</td>
<td>SOME PRESSURE</td>
<td>VERY LITTLE PRESSURE</td>
<td>NO PRESSURE</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>10. Only go out with someone your friends say is okay to date?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>11. Stay away from shoplifting?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>12. Avoid fighting, not try to act tough?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>13. Talk or act the same way as your friends do?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>14. Get drunk (get &quot;a buzz&quot;)?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>15. Wear your hair (or make-up) like your friends do?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>16. Smoke marijuana?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>17. NOT use hard drugs?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>18. &quot;Party,&quot; be rowdy?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>19. Shoplift or steal?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>20. Drink beer or liquor?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>21. Keep your virginity (NOT have sex, or &quot;go all the way&quot;)?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>22. NOT &quot;trash&quot; things (not vandalize)?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>23. Smoke cigarettes?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>24. Wear the same kind of clothes your friends wear?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>25. Have the same opinions that your friends have?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>26. NOT smoke marijuana?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>27. NOT get drunk?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
APPENDIX B

PEER CONFORMITY DISPOSITION SCALE

Here are some situations that you might find yourself in. READ each one. Then decide what you would REALLY DO if you were in that situation, and HOW SURE you are about what you would do. Mark your answer in the appropriate space on the line below the question. REMEMBER, mark JUST ONE "X" for each situation.

a. One day after supper, you and a couple of your best friends meet at the school. NO one is around and your friends decide that you should all write on the walls of the school. You don't think it's a good idea but your friends tell you to do it anyway. You would?:

WRITE ON THE SCHOOL WALLS

(definitely) (probably) (unsure) (probably) (definitely)
(not) (not)

b. A couple of your best friends are getting together tonight to watch a TV program. They want you to come too, but your favorite show is on at the same time. You would?:

WATCH TV WITH YOUR FRIENDS

(definitely) (probably) (unsure) (probably) (definitely)
(not) (not)

c. You go with a couple of your best friends on Halloween. They're going to soap windows, but you're not sure whether you should or not. Your friends all say you should, because there's no way you could get caught. You would?:

SOAP WINDOWS

(definitely) (probably) (unsure) (probably) (definitely)
(not) (not)
d. You meet a couple of your best friends in the park one Saturday. One of your friends brought along a frisbee, and all of your friends want to play, but you want to do something else. You would?:

PLAY FRISBEE

(______) (______) (_____ ) (______) (______)

definitely probably unsure probably definitely

not not

e. You're making something special, and just as you start working on it, a couple of your best friends come by and ask you to do something with them. You would?:

DO WHAT YOUR FRIENDS WANT

(______ ) (______ ) (_____ ) (______ ) (______ )

definitely probably unsure probably definitely

not not

f. You and a couple of your best friends are walking home from school when you come across a house that's being built. There's a sign saying "No Trespassing," but your friends all want to go inside. You don't think it's a good idea, but they say "Come on!" You would?:

REFUSE TO GO INSIDE

(______ ) (______ ) (_____ ) (______ ) (______ )

definitely probably unsure probably definitely

not not

g. You're getting together with a couple of your best friends tonight, and you're going to go get something to eat. Your friends all want to go to one place, but you feel like going to the place next door. You would?:

GO NEXT DOOR AND MEET YOUR FRIENDS LATER

(______ ) (______ ) (_____ ) (______ ) (______ )

definitely probably unsure probably definitely

not not
h. You go for a walk around a lake with a couple of your best friends and see a boat on the shore. It isn't tied, and no one is around. Your friends all agree to take it out on the lake for a ride. You don't think you should, but they tell you to get in or they'll leave you. You would:

**GET IN AND GO FOR A RIDE**

<table>
<thead>
<tr>
<th>definitely</th>
<th>probably</th>
<th>unsure</th>
<th>probably</th>
<th>definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>not</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

i. During gym one day, the teacher gives you free time. You want to jump on the trampoline. A couple of your best friends are going outside to play volleyball and they want you to join them. You would:

**USE THE TRAMPOLINE**

<table>
<thead>
<tr>
<th>definitely</th>
<th>probably</th>
<th>unsure</th>
<th>probably</th>
<th>definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>not</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

j. On the way home from school, you and a couple of your best friends stop at a store to get something to eat. You notice an open bag of candy. Your friends all take a piece, but you don't like the idea. They tell you to go ahead and take one. You would:

**REFUSE TO TAKE ANY CANDY**

<table>
<thead>
<tr>
<th>definitely</th>
<th>probably</th>
<th>unsure</th>
<th>probably</th>
<th>definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>not</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

k. You and a couple of your best friends are fooling around in an empty lot next to a house and accidentally break one of the windows of the house. Your friends want to take off and not tell anyone in the house. You don't think that's right, but they tell you to hurry up and come. You would:

**GO AWAY WITH YOUR FRIENDS**

<table>
<thead>
<tr>
<th>definitely</th>
<th>probably</th>
<th>unsure</th>
<th>probably</th>
<th>definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>not</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. You and a couple of your best friends find a sheet of paper that a teacher lost. On the paper are the answers to a test that you're going to have tomorrow. Your friends all plan to study from it, and they want you to go along with them. You don't think you should, but they all say to do it anyway. You would?

**STUDY FROM THE PAPER**

<table>
<thead>
<tr>
<th>definitely</th>
<th>probably</th>
<th>unsure</th>
<th>probably</th>
<th>definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>not</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

m. On Saturday you go to an amusement park with a couple of your best friends. You are all standing in line for one ride, but you really want to go on another one instead. While you're still in line with your friends, you see a guy taking tickets for the ride you like better. You would?

**GO ON THE RIDE YOU WANT TO**

<table>
<thead>
<tr>
<th>definitely</th>
<th>probably</th>
<th>unsure</th>
<th>probably</th>
<th>definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>not</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

n. Tomorrow a group you belong to is having a picnic. You want to go early, but your friends want you to go with them a little later. You would?

**GO LATER WITH YOUR FRIENDS**

<table>
<thead>
<tr>
<th>definitely</th>
<th>probably</th>
<th>unsure</th>
<th>probably</th>
<th>definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>not</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

o. You're going to play some game and you're captain of the team. A kid you don't know wants to play. You feel that anyone who wants to play should be able to. Your friends tell you not to let him play because no one knows him. You would?

**NOT LET THE KID PLAY**

<table>
<thead>
<tr>
<th>definitely</th>
<th>probably</th>
<th>unsure</th>
<th>probably</th>
<th>definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>not</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. Is seeing a psychiatrist for your drug or alcohol problem all right with you?
   a. Yes
   b. Not certain
   c. No

2. Are the methods of treatment for drug and alcohol problems:
   a. Superior to the methods of treating physical illness
   b. About equal to the methods of treating physical illness
   c. Inferior to the methods of treating physical illness

3. The care a patient receives in a psychiatric hospital's drug and alcohol treatment program is likely to be:
   a. Good
   b. Fair
   c. Poor

4. Do you think a psychiatrist will be successful in helping you with the problem you have with drugs and alcohol?
   a. Very likely
   b. Probably
   c. Very unlikely

5. Treatment for drug and alcohol problems is:
   a. Usually successful
   b. Sometimes successful
   c. Rarely successful

6. When a patient leaves a drug and alcohol treatment center he/she is usually
   a. Improved
   b. Unchanged
   c. Worse

7. Seeing a psychiatrist would be helpful to:
   a. Many people
   b. Some people
   c. Very few people
8. After receiving treatment for drug and alcohol problems, most patients feel
   a. Much better
   b. Somewhat better
   c. No better

9. In dealing with drug and alcohol problems, do you believe that psychiatric hospitals are:
   a. Doing a good job
   b. Doing a fair job
   c. Doing a poor job

10. Would you encourage a friend with a drug and alcohol problem to see a psychiatrist?
    a. Yes
    b. Not certain
    c. No

11. Do you think that psychiatric treatment helps people with their drug and alcohol problems?
    a. Yes
    b. Not certain
    c. No

For the following statements, CIRCLE the degree to which you Agree or Disagree

12. I feel uneasy going to a psychiatrist because of what some people will think.
    a. Agree strongly
    b. Agree
    c. Disagree
    d. Disagree strongly

13. There is nothing wrong with admitting that you have a drug and alcohol problem that requires psychiatric help.
    a. Agree strongly
    b. Agree
    c. Disagree
    d. Disagree strongly

14. If I thought I needed psychiatric help, I would get it no matter who knew about it.
    a. Agree strongly
    b. Agree
    c. Disagree
    d. Disagree strongly
15. Being a patient in a drug and alcohol treatment center is a blot on a person's life.
   a. Agree strongly
   b. Agree
   c. Disagree
   d. Disagree strongly

16. It is all right if others know that I am a patient at a psychiatric hospital's drug and alcohol treatment program.
   a. Agree strongly
   b. Agree
   c. Disagree
   d. Disagree strongly

17. Having had a problem with drugs and alcohol carries with it a lot of shame
   a. Agree strongly
   b. Agree
   c. Disagree
   d. Disagree strongly

18. I do NOT feel that my receiving treatment at a psychiatric hospital for a problem with drugs and alcohol should be "covered up."
   a. Agree strongly
   b. Agree
   c. Disagree
   d. Disagree strongly

19. Others will think poorly of me if they find out that I have been a patient at a psychiatric hospital for a problem with drugs and alcohol.
   a. Agree strongly
   b. Agree
   c. Disagree
   d. Disagree strongly

20. I want my friends to know that I am a patient at a drug and alcohol treatment center.
   a. Agree strongly
   b. Agree
   c. Disagree
   d. Disagree strongly
APPENDIX D

SELF-REPORTED BEHAVIOR INDEX

Think back over the past month, before you came here. HOW MANY DAYS in the past month (before you came here) have you:

*Responses should be 0-31*

1. Smoked a cigarette? __________
2. Taken something from a store without paying for it? __________
3. Stayed out past curfew (past the time your parents said you should be home? __________
4. Cut a class or skipped school? __________
5. Had a beer or some hard liquor? __________
6. Looked for trouble? __________
7. Smoked marijuana? __________
8. Done something that people would say was vandalism? __________
9. Done some drugs (besides marijuana)? __________
10. Taken something (on purpose) that did not belong to you? __________
11. Drank enough to get drunk? __________
APPENDIX E

PARENT'S CONSENT

I am asking for permission to administer a series of questionnaires to your child as part of a study entitled, "Conformity Disposition and Perceived Peer Pressure: Implications for the Treatment of Drug and Alcohol Abuse Among Adolescents." As a Master's student in Educational Psychology at the University of Arizona and an employee of this facility, I am trying to learn more about adolescents' attitudes toward treatment based on how likely they are to "go along with the crowd" and how much pressure they feel from their friends to behave in certain ways.

If you give permission for your son or daughter to participate in this study, I will arrange an individual session during his/her free time. Your child will be given an explanation of the study much like this one, allowed to ask questions, informed that he/she may end the session at any time, and asked to indicate by signing a consent form whether or not he/she wishes to participate.

All of the adolescents who agree to the session will be asked to complete a series of questionnaires consisting of the Peer Pressure Inventory, the Peer Conformity Disposition Scale, the Self-Reported Behavior Index, the Treatment Attitudes Questionnaire, and the Psychiatric Attitudes Battery. The session will last approximately 20-30 minutes, and the answers your child gives will be completely confidential, seen only by me and not by your child's doctors or other hospital personnel. I will simply score and analyze the answers given by all of the adolescents and write a summary report with no names on it. I will share this report with the professors in my department and with you if you will provide me with your address. I am confident that there will be no risks to your child if he/she participates. The benefit to participating will be insight into his/her behavior and feelings. Whether you choose to involve your child in this study is entirely up to you and has no implications for your child's treatment.

Thank you for your time and help.

Sincerely,

Jean Raniseski
"I have read the above description and understand the nature, demands, risks, and benefits of the study. I understand that my child is free to ask questions about the study, refuse to participate, or end the session at any time without incurring any ill will. I also understand that the answers he/she gives will be seen only by the researcher. Finally, I understand that this consent form and my child's consent form will be filed in an area designated by the University of Arizona's Human Subjects Committee, that it can be seen only by the principal investigator or her authorized representatives, and that I may have a copy of this consent form and my child's consent form upon my request."

Parent's Signature ___________________________ Date ______

Full Name of Child ___________________________


"I have carefully explained to the subject's parent the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in his/her child's participation and his/her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding."

Signature of Investigator _______________________ Date ______
APPENDIX F

SUBJECT'S CONSENT

I am requesting your voluntary participation in the completion of some questionnaires. The questionnaires will address issues about your friends, what you do in certain situations, things you have done in the past month, and how you feel about being in treatment. About 20-30 minutes of your time will be required for completion of these questionnaires and will indicate your consent as a willing participant in this study. There are no risks involved in this study. All information received will be treated with confidentiality. No one, including your doctor or other hospital personnel will be given this information. If the results of the study are published in a professional journal, your identity will not be revealed. You are free to withdraw from the study at any time without incurring ill will or in any way affecting your treatment. The benefit to participating in this study will be possible insight into the way you behave and feel.

Thank you for your time and help.

Sincerely,

Jean R.

________________________________________________________________________

"I have read the above 'Subject's Consent'. The nature, demands, risks, and benefits of the project have been explained to me. I understand that I may ask questions and that I am free to withdraw from the project at any time without incurring ill will. I also understand that this consent form will be filed in an area designated by the Human Subjects Committee with access restricted to the principal investigator or her authorized representatives of the Educational Psychology department. A copy of this consent is available to me upon request."

Subject's Name (Please print) _________________________________

Subject's Signature _________________________________ Date ______
"I have carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in his/her participation and his/her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding."

Signature of Investigator __________________________ Date _______
REFERENCES


