Scared Straight?

Why to Avoid Scare Tactics

By Kathy Asper

Mock DUI crashes. Gruesome photos. Horror stories told by recovering addicts. Do these and other "scare tactics" convince teenagers not to use drugs? Research says probably not.

Some of the most influential research in the effectiveness of scare tactics occurred in 1975 in the Netherlands when two fresh-out-of-college young adults were hired to organize drug education in the Rotterdam schools. Questioning the widespread assumption of the time that all drug education reduces use, they soon secured funding to evaluate programming.

They implemented an innovative study involving four groups of 1,035 14- to-16-year-olds. One group whose students received no specific programming served as the important "control group." The second group (called "warning" or "mild horror approach") stressed the dangers and moral dimensions of drug use; the third ("factual") provided information to increase knowledge about drugs. And the last group ("personal") didn't focus on drugs at all, but offered students the chance to participate in informal groups where they could discuss the problems of adolescents.

The results of the research were surprising. None of the approaches deterred the few regular drug users (mostly marijuana), but there was a significant difference in impact on the non-users. In the control group, 3.6 percent of students tried drugs between the baseline and later measures. This was assumed to be the "natural" rate of increase. Those in the factual group used at a slightly higher rate of 4.6 percent. In the warning group, twice the number of students tried drugs (7.3 percent). So, it appears that the use of scare tactics actually increased drug use. Surprisingly, the personal group had a lower rate of use than the control group. It appeared that allowing students to discuss personal issues served to reduce drug use. This approach served as an informal template for the interactive drug prevention approaches that were researched and proven effective toward the turn of the century, most notably Dr. Gilbert Botvin's LifeSkills Training.[1]

Another significant review of scare tactics occurred in 2002, when the billion-dollar National Youth Anti-Drug Media campaign was evaluated. Focus groups were conducted with test ads for an anti-cannabis TV campaign. Students viewed a series of graphic ads depicting consequences of "hard" drug use that ended with a teenager's account of how it all started with marijuana. Amazingly, the hard-hitting sequence left viewers feeling MORE positive about cannabis and more likely to say they would use the drug.[2]

So, there is valid research proving that scare tactics don't work. The question then is, WHY don't they work?

In the anti-cannabis study, the students who were already planning not to use cannabis were unmoved by the ads, while those most likely to use tended to "move towards disbelieving that regular marijuana use has negative consequences." These students probably discounted or outright rejected the ads because they knew people who were using (or maybe were using themselves) and weren't seeing the consequences depicted. [3] Sadly, these students might then reject other things that adults tell them, thinking it's all one big con job.

Also, the underlying assumption of using scare tactics is that adolescents don't really understand the dangers of using drugs. It's hoped that teens, armed with this information, will make logical and rational decisions not to smoke, drink or use other drugs.[4] However, recent research using Magnetic Resonance Imaging (MRI) has shown that the human brain is actually a

work in progress.[5] The regions of the brain responsible for governing impulses and exercising judgment are not fully developed during adolescence,[6] and in fact, do not finish developing until the early to mid-20s.[7] Add to this the fact that teens often feel they are invincible, and the message that they actually take from our drug prevention lesson just might not be the one that we intended.

Proceed with Caution

Before having a recovering addict speak to youth, there are some important issues to consider.

1. A person should be in recovery for at least five to seven years before he or she is allowed or invited to present information to students. This protects the addict, since talking about drug use may trigger a relapse. And, since these people are further along in their recovery, the content of their messages will usually be more sound than that of a newly recovering person.

2. If possible, have a prevention and/or treatment professional co-present, or at least be around for the question-and-answer session. This is extremely important since the addict will only be able to answer questions about his or her own experiences. He or she often will not fully understand the effects the drug had, or will not be familiar with key components of addiction, the recovery process, and other issues.

These tips are from the Web site of the Meth Awareness and Prevention Project of South Dakota (MAPP-SD), www.mappsd.org. Look under the "schools" section of the site for more considerations about using recovering people to speak to youth. MAPP-SD is a project of Prairie View Prevention Services, Inc.

During the last few years while working specifically as a meth prevention coordinator, I've provided hundreds of presentations about how meth affects the brain. Except for a few trainings where I cautioned students about meth lab garbage they might accidentally stumble upon, my focus has been on educating adults. The reason? At this time, there are no existing, evidence-based curricula for meth prevention (those that have undergone rigorous testing to prove their effectiveness). Consequently, I do not feel comfortable sharing the signs and symptoms of meth use with teens and young adults. I fear that the initial effects of use (especially weight loss, energy, strength and confidence) will be too enticing for some of them to resist.

So what can we do to protect our children from meth? We can provide comprehensive drug prevention programming for students in kindergarten through 12th grade. We can educate parents and school staff (including not only teachers and administrators, but bus drivers, janitors, aides and others) to recognize and appropriately respond to signs of meth use and symptoms of child endangerment due to a caregiver's use. We can seek assistance from appropriate resources. One resource you might find helpful is www.mappsd.org. It provides several tools for educators, including eight cautions when considering presentations by recovering meth addicts and a listing of meth resources that can be used to supplement comprehensive prevention programming.

In 1975, two Dutch educators challenged the status quo in drug prevention by questioning a "tell them the awful facts" philosophy. Over 30 years later, prevention educators are still striving to find ways to keep teens safe. The difference is we now have research to help guide our efforts.

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References

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[3] Ibid

[4] Botvin, Gilbert J., Ph.D., "Prevention Drug Abuse Through the Schools: Intervention Programs That Work." www.nida.nih.gov/MeetSum/CODA/Schools.html

[5] "Teenage brain: A work in progress." National Institute of Mental Health 2001. www.nimh.hih.gov/publicat/teenbrain.cfm

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