



Volume 1 Issue 3

www.socialnorm.org

January 2006

The Social Norms Review

**Preventing Alcohol-Related Harm
Among Australian Rural Youth:
Investigating the Social Norms Approach**
Clarissa Hughes (Cook), Ph.D.

**Social Norms as Treatment:
Clinical Uses of a Prevention Strategy**
Robert J. Chapman, Ph.D.

Introduction

The social norms approach first gained widespread attention in the 1990s as an effective strategy to enhance the health and safety of college student drinkers in the United States and to reduce the incidence among them of alcohol-related negative consequences. As is well known, the approach has since been used effectively to address other issues—tobacco use, seat-belt use, and tax compliance, to name a few—and in other settings, such as high schools and communities. Now, with projects underway in other countries, the social norms approach is slowly gaining ground outside the U.S. as well. One example of this is a small number of universities that recently began to pilot this approach to address college student drinking in Canada.

Dr. Clarissa Hughes' article in this issue of *The Social Norms Review* provides a detailed look at the background of a social norms project due to begin this year in two rural municipalities in Tasmania. The goal of this project—the first ever in Australia—will be to target adolescent alcohol use and

alcohol-related harm. This is an exciting development, and in future issues of the *Review* we hope to provide updates on this and other projects currently underway abroad.

Dr. Robert Chapman is perhaps most widely known for *News from the Front*, a biweekly newsletter of The Network: Addressing Collegiate Alcohol & Other Drug Issues. As a long-time practitioner, he has extensive experience providing counseling to college students in the specific area of alcohol and other drug services. Dr. Chapman's article is an interesting description of his use of the social norms approach in a clinical setting. As such, it provides yet another example of how this approach is breaking new ground.

As always, we hope that you find this issue of the *Review* to be informative and helpful, and we welcome your comments and suggestions.

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The Social Norms Review is a quarterly electronic publication of the National Social Norms Resource Center. Issues appear in January, April, August, and October.

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Preventing Alcohol-Related Harm among Australian Rural Youth: Investigating the Social Norms Approach

Clarissa Hughes (Cook), Ph.D.

There is a sense of urgency surrounding a key health problem of our time: high-risk drinking (NHMRC, 2001). Misuse of alcohol is responsible for much of the acute and chronic disease burden, and is associated with mental health problems, suicides, and motor vehicle and other accidents (Australian Institute of Health and Welfare, 1999; Baker et al., 1992; Chikritzhs et al., 2003; Collins and Messerschmidt, 1993; d'Abbs et al., 1994; Heale et al., 2002; Jonas et al., 2000; Mason and Wilson, 1989; McBride et al., 2000; Fombonne, 1998; Hall and Farrell, 1997; White and Humeniuk, 1994). Risky drinking among young people, in particular, is widely regarded as an important public health issue not only because of the various harms incurred in the short term, but also because of the multitude of health, personal and social implications that are likely to affect people later in the life-course if such drinking patterns become entrenched (Loxley et al., 2004).

Australian youth in rural and remote communities are of particular concern since they consume alcohol at more harmful levels than their metropolitan counterparts (Williams, 1999).

Despite substantial public investment and an array of different approaches, the 'problem' of binge-drinking has shown itself to be a highly complex and particularly intractable issue:

In our efforts to solve the problem of binge drinking, we have none of the precision that

we like; it is not an infectious disease that can be controlled or eradicated by the application of so many units of some treatment, or prevented by the careful removal of clearly defined personal, social, or environmental factors that lead to illness (Keeling, 2000).

In Australia, as elsewhere, there is growing recognition that it is preferable to take a preventive approach to youth binge-drinking and alcohol problems more generally, rather than wait until the problem is apparent. Preventive programs are by no means a 'new invention,' however school-based alcohol abuse prevention programs have been part of Australian primary and high school education for many decades. Commentators have noted a number of phases of development in this country which have tended to mirror developments overseas (Steffian, 1999).

Early prevention work within schools tended to focus on the provision of information to students, particularly concerning the pharmacological dangers of substance use and the possible risky consequences of drinking. These programs often incorporated deliberate scare-tactics and have been labeled 'health terrorist' approaches due to the underlying assumption that scaring the living daylights out of people will 'scare the health into them' (Perkins, 2003). Put simply, it was believed that 'if young

people just knew how horrible drugs were and what they did to their brains and bodies, then they would not use them' (Hogan, 2002). Sometimes more comprehensive school-based alcohol and drug education programs were delivered in conjunction with law enforcement agencies, with the aim of educating young people about the likely legal, social and health implications of the use of illicit drugs and the misuse of licit drugs.

Despite some residual 'scare tactic' elements within contemporary programs, the information approach as a stand-alone method of tackling high-risk drinking among youth was 'an acknowledged failure by the late 1970s' (Midford, 2002). Ironically, some information-based programs have resulted in 'more educated drug users' as well as increased levels of use (Hogan, 2002). The ensuing phase of school-based prevention took a more holistic approach: seeking to build the self-esteem of young people so that they were less vulnerable to the vagaries of substance abuse. Sometimes these programs included resistance training components that sought to 'inoculate' youth against overt peer-pressure to engage in risky behaviors. Over time such 'affective' programs suffered the same fate as their predecessors the 'information' programs: they were gradually, if reluctantly, recognized as having only limited efficacy.

With the exception of some more recent and more sophisticated 'social influence' programs (Midford, 2002), alcohol programs for young people have not achieved great success, either in

Australia or elsewhere despite 'good intentions and a parade of promising practices' (Keeling, 2000). On the whole, alcohol educators here and overseas find themselves in a frustrating and disheartening position whereby, despite determined efforts, prevention programs generally fail to deliver sustained behavioral modification (Steffian, 1999).

Looking for Alternative Approaches

In searching for possible explanations for lack of effect it is necessary to examine the assumptions underpinning the various prevention efforts. With respect to alcohol programs, information-based approaches assume that young people will be motivated to change by appeals to long-term health consequences or mortality. With respect to the so-called 'affective' and 'inoculation' approaches, there is an underlying assumption that low self-esteem is a significant causal factor in harmful patterns of alcohol consumption among young people. Similarly, although peer factors have repeatedly been shown to be fundamental to youth drinking behaviors (Borsari and Carey, 2001), it is conceivable that peer pressure doesn't operate in precisely the way program designers assumed that it does.

With such issues in mind, there is merit in the development of a 'sociology of drinking'. D'Abbs recognized that although the public health approach to alcohol-related problems is valuable from a descriptive and risk-factor identification perspective, it "fails to acknowledge the extent to which, and the many ways in which, drinking is a

social as well as an individual act (d'Abbs, 2002)". There is strong evidence that a sociological approach to alcohol consumption 'matters very much'

not only because drinking is a social act, but because virtually the entire public health repertoire of policies and measures are... attempts to intervene in the social control of drinking (d'Abbs, 2002).

As noted earlier, some of the more recent 'social influence' approaches to alcohol abuse prevention are yielding promising results. This could be because they incorporate environmental/cultural factors and acknowledge and utilize complex social control processes, rather than having a blinkered focus on the individual's knowledge, values or personality.

The pursuit of a theoretically sophisticated sociological approach to alcohol consumption represents an important way forward for rational program design and evidence-based policy development. One recent prevention approach that is gaining in popularity and deemed worthy of the label of 'sociologically-informed', is known as 'Social Norms' (SN). SN has a theoretical basis in social-psychology, and draws upon theories of peer identity formation, conformity and cognitive dissonance (Perkins, 1997). A distinctive feature of SN is its clarification and utilization of peer-related influences on behavior. As explained by a pioneer of the approach:

Research has long pointed to the dramatic power of peer influence in adolescence and young adulthood, but what has not been adequately considered in previous research and prevention strategy is whether this peer influence comes simply from what other peers actually believe is the right thing to do and how they behave, or from what young people think their peers believe is right and how they think most others behave (Perkins, 2003).

The SN approach has been extensively employed in the United States, and has been heralded as an effective strategy for reducing alcohol-related harm in youthful populations by identifying and correcting such attitudinal and behavioral misperceptions. The following section of this paper, sketches out how the approach has developed since the foundational research was conducted nearly two decades ago, and considers whether or not the encouraging results achieved overseas would be likely to be achieved in the Australian context.

About the Social Norms Approach

The foundational research was undertaken in the late 1980s by social scientists Perkins and Berkowitz, who discovered widespread misperception of alcohol-related attitudes and behaviors among college students at Hobart and William Smith Colleges in upstate New York. Specifically, they found that students consistently overestimated how often and how much their peers drank, as well as overestimating their peers'

support of risky drinking behaviors. Perkins and Berkowitz subsequently theorized that much high-risk activity stems from people wishing to, or feeling pressured to, conform to the behavior and expectations of ‘imaginary peers’ (Perkins, 2003).

These early contentions have been supported by more recent studies—for instance, Beck and Trieman’s finding that “teens’ drinking behaviors are not driven so much by a need for peer approval or to be accepted by a group, but rather by what is perceived of as normal behavior among one’s close friends (Hogan, 2002; Beck and Treiman, 1996).” Essentially, what is problematic about misperception is the self-fulfilling prophecy (Merton, 1957) effect whereby the (often erroneous) assumption that ‘everyone is doing it’ leads to a situation where ‘everyone does it’. Certainly, many studies demonstrate that perceptions of drinking norms predict, or are at least positively correlated with, individual drinking behaviors (Borsari and Carey, 2001; Thombs et al., 1997; Page et al., 1999). However, just as inflated perceptions of drinking norms contribute to a social environment that is supportive of high-risk drinking, accurate norm perceptions will tend to have the opposite effect (Steffian, 1999). Therein lies the ‘secret weapon’ of this important alternative to ‘health terrorism’:

The strategy of the social norms approach, put simply, is to communicate the truth about peer norms in terms of what the majority of students actually think and do, all on the basis of

credible data drawn from the student population that is the target (Perkins, 2003).

The basic stages of an SN intervention are as follows: The initial phase involves the collection of baseline self-report data about use and attitudes. These data are then analyzed and the key messages are crafted, with an emphasis on positivity. (For example, ‘70% of Greentown High students have three or fewer drinks when they party’). Scare tactics and negative slants are notably absent. The next phase involves the incorporation of the key messages (i.e. the ‘actual norms’) into a media campaign utilizing radio, flyers, screensavers, and newspaper ads, for example, that is then delivered intensively to the target population. The population from which the baseline data were collected is always the intended recipient of the media campaign, but sometimes additional groups (such as parents and teachers) are included. The media phase is then monitored for impact in terms of recognition and understanding of the message, changes to norm perceptions and resultant changes in behavior.

Social norms interventions are rapidly gaining in popularity in the United States. In a survey of 4-year colleges nationwide in 1999, 20% of the colleges surveyed reported having conducted social norms marketing campaigns, and by 2001 this figure had risen to nearly 50% (Weschler, 2004). There is a growing body of evidence of encouraging and often dramatic reductions in high-risk drinking among target populations in metropolitan and non-metropolitan settings. For instance,

the University of Arizona reported a 29% reduction in 'heavy episodic drinking' over a three-year period (Glider et al., 2001). Equivalent figures for other institutions include a 21% reduction over two years at the University of Missouri-Columbia, and a 44% reduction over 10 years at Northern Illinois University (Haines, 1996). Other institutions (Peeler et al., 2000) reported significant increases in the proportion of abstainers (teetotalers) among their student populations. Although the majority of SN interventions have been conducted at colleges and universities, the approach is also yielding promising results at high-schools (Linkenbach, 1999; Johannessen et al., 1999).

Despite a growing band of enthusiastic followers, the SN approach does have its critics. Weschler, for example, recently argued that "...there is no evidence from scientifically rigorous evaluations supporting the effectiveness of...social norms marketing campaigns (Weschler, 2004)." Although their conclusions have been refuted on methodological grounds (Perkins and Linkenbach, 2003), this group of Harvard-based academics remain vocal critics of the SN approach. Admittedly, there have been isolated examples of 'failed' SN interventions. Werch, for instance, reported that an intervention designed to prevent heavy episodic drinking among first-year college students "failed to produce any differences in self-reported alcohol use or alcohol-use risk indicators" (Werch, 2000; Clapp et al., 2003; Trockel et al., 2003). However, ineffective interventions do not, in themselves, constitute a satisfactory basis for dismissing the SN approach. The evidence base in support

of the method is sufficiently large and robust to warrant detailed consideration of the potential 'fit' of SN within the Australian social, cultural and policy environments.

Would Social Norms Interventions Work in Australia?

Having learned something of the theoretical underpinnings of SN and the details of some interventions, is the task of considering whether or not the 'fit' between SN and the Australian policy and social environments is likely to be a comfortable one? Certainly, there are reasons to think that SN interventions might not be readily 'transplantable'. With few exceptions, virtually the entire body of evidence is U.S.-based. There may be important cultural or social differences between Australia and the U.S. (for instance, less pervasive peer orientation among adolescents) that would render SN interventions less effective in the former than in the latter. The American legal drinking age is 21 as opposed to 18, which might also have implications for program implementation.

Furthermore, the United States' 'War on Drugs' is often held as the 'bastion of opposition' to Australia's drug policy position that is based on a 'harm reduction' approach (Roche et al., 1997; Wink, 1996). A detailed discussion of the similarities and differences between the drug policies of the two countries is not only outside the scope of this article, it is of limited value for the current discussion. What matters is not how different the Australian and U.S. drug policies are, but whether SN is itself

compatible with a harm minimization framework.

Although there has been some controversy surrounding the terms ‘harm minimization’ and ‘harm reduction’ (Single and Rohl, 1997) and the extent to which they are interchangeable, broadly speaking they refer to:

a policy of preventing the potential harms related to drug use rather than trying to prevent the drug use itself. Harm reduction accepts as a fact that drug use has persisted despite all efforts to prevent it and will continue to do so (Duncan et al., 1994).

The principle of harm minimization or harm reduction provided the basis for Australia’s National Campaign Against Drug Abuse (launched in 1985) as well as its successor, the National Drug Strategy (d’Abbs, 2002). Critics of harm minimization have suggested that it condones illicit drug use and other risky behaviors because it does not promote non-use, or even necessarily aim for a reduction in use. However, as Plant and his colleagues explain, harm minimization is ‘neutral on the virtue or shame attached to such behaviors’ (Plant et al., 1997) and although it does not seek to minimize alcohol intake *per se*, it is by no means incompatible with abstentionist aims.

There are good indications that SN interventions will fit comfortably within our harm minimization policy framework. Unlike health promotion approaches that seek to scare people off

behaviors because they are risky (or shame people out of them because they are ‘bad’), SN approaches takes a neutral stance: they do not present alcohol consumption as either evil or virtuous. Importantly, there is an assumption that many young people do and will continue to consume alcohol—the challenge lies in finding evidence-based ways to diminish the likelihood of them harming either themselves or others in the process. SN is a promising candidate in this regard.

Trialing Social Norms in Australia

We are currently exploring the possibility of running the first Australian trial of the SN approach to substance abuse prevention. Although the finer details of the trial are yet to be determined, it is possible to sketch out some of the defining features at this point. It is envisaged that the trial will be both multi-state and multi-site, and will initially focus upon reducing binge-drinking among high-school aged children in a Tasmanian rural community.

The initial trial will take a collaborative, multidisciplinary approach, with the involvement of both the University Department of Rural Health and the Tasmanian Institute of Law Enforcement Studies from the University of Tasmania, as well as Tasmania Police, health service providers and various community/non-government organizations, local government and schools. This is in recognition of the importance of involving a diverse mix of individuals and institutions in prevention efforts (Roche and Stockwell, 2004). A

subsequent phase (dependent on ongoing funding) is planned to trial the approach with an indigenous community in another Australian state. If this later phase of the trial proceeds as planned, it will be a 'world first', as no SN interventions to date have focused exclusively on an indigenous population.

The target population will be students in early high school, with the possibility of also including upper primary school students. The focus on youth in these particular age-groups is well-supported by the literature (Johnston et al., 1989; Dielman, 1994; Duncan et al., 1994), with strong agreement that the late primary/early high school years represent 'the optimal time for initiating youth drug interventions' since it tends to coincide with the onset of experimentation (Midford et al., 2002).

Like many of the more recent SN interventions in the U.S., the Australian trial will take a broad community focus involving teachers and parents as well as students. Again, the inclusion of a parenting component in a youth-focused substance abuse prevention intervention is well supported by the literature (Rohrbach et al., 1994; Beck and Lockhart, 1992). The trial will aim to identify and correct any misperceptions the parents might have of youth alcohol consumption in that community. An additional, though no less significant aim is to use the SN approach to strengthen parenting behaviors that are supportive of safe alcohol consumption. Just like teens, parents' behavior can be influenced by erroneous perception of 'peer' (i.e. other parents') behaviors and attitudes:

"if parents underestimate how frequently other parents are using certain protective strategies, this misperception may serve to undermine their own resolve to adopt those strategies or apply them consistently. Stated simply, it is harder for parents to uphold firm rules and standards when they believe they are among the few parents trying to do so (Hancock and Henry, 2003)."

The parenting component might be crucial to the success of an indigenous community intervention; there are indications that parental/guardian influence is stronger among indigenous youth than it is among non-indigenous youth. As O'Leary points out, this "presents the opportunity to revive cultural responsibility for younger relatives/community members as a strategy to prevent early, excessive, and prolonged alcohol use" (O'Leary, 2002).

The broad, community-based approach of the proposed trial maximizes potential reinforcement of the key messages (Perry and Kelder, 1992; Perry et al., 1996). Furthermore, it seeks to prompt the 'environmental' level changes deemed necessary by Midford and colleagues, who argue that:

curing or removing the individual problem drinker will not result in a reduction in alcohol-related harm, because the community dynamics which caused these problems are unchanged. In order to change the aggregate level of alcohol-related harm,

environmental changes have to occur (Midford et al., 2002).

Conclusion

We are enthusiastic about the potential of the SN approach to reducing high-risk alcohol consumption among young people. It is an evidence-based prevention model that will hopefully avoid some of the ‘unintended consequences’ of media coverage and many of the standard scare-tactic health promotion approaches, which themselves contribute to the perception of the ‘normality’ of youth binge-drinking:

News accounts and other messages about student drinking that are designed to underscore the seriousness of the problem can have the unintended consequence of reinforcing the misperception that heavy drinking is the norm. Ironically, the very information that is designed to motivate corrective action may instead bolster a set of beliefs that make the problem more resistant to change (Linkenbach and Perkins, 2003).

Although alcohol consumption has been the focus of most SN interventions in the U.S and will also be the focus of the Australian trial, the approach is by no means restricted to the area of substance abuse. There is a growing body of evidence that a variety of health and social justice issues are amenable to change via the correction of misperceptions. For instance,

encouraging results have been gained in relation to smoking (Hancock and Henry 2003; Linkenbach and Perkins, 2003), homophobic and racist behavior (Smolinsky, 2002; Berkowitz, 2002), teenage pregnancy and sexual assault (Berkowitz, 2002; Bruce, 2002).

TILES and UDRH are excited about conducting the first Australian trial of the SN approach, and are confident that the collaboration involving the University of Tasmania, Tasmania Police, local and state government representatives, health care professionals, schools and rural community will work effectively towards achieving shared objectives. In the process of meeting important research priorities identified by the Australian government (Commonwealth of Australia, 2002; Roche and Stockwell, 2002) this collaborative work will stimulate Australian debate about SN and provide evidence concerning its potential ‘transplantation’ to this country as a method for reducing alcohol-related harm. Adding to the body of knowledge about socio-cultural determinants of alcohol consumption will also contribute to the long-overdue development of a ‘Sociology of Drinking’. All partners in this project enthusiastically embrace the opportunity to examine an alternative approach that could revolutionize health promotion and make significant contributions to the health of rural and remote Australians.

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Suggested citation:

Cook, C. (2005). Preventing alcohol-related harm among Australian rural youth: investigating the 'Social Norms' approach (Briefing Paper no. 1): Tasmanian Institute of Law Enforcement Studies, University of Tasmania, Australia.

Project Update

At the time of the original publication of this article, Clarissa Hughes (Cook) and colleagues had just submitted a funding application to the Alcohol Education and Rehabilitation Foundation.

The funding bid was successful and the collaboration has been awarded \$500,000(AU) to conduct the first Australian trial of the Social Norms approach. The two-year project is due to commence in 2006 and will target adolescent alcohol use and alcohol-related harm in two rural municipalities in Tasmania.

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Social Norms as Treatment: Clinical Uses of a Prevention Strategy

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Social Norms Marketing: An Overview

The social norms approach has its roots in the social psychological research of Solomon Asch's social conformity experiments dating back 50 years (Baron and Byrne, 1997). As a prevention strategy, it has been specifically studied regarding the issue of high-risk collegiate alcohol use since the early work of H. Wesley Perkins and Alan Berkowitz at Hobart William Smith Colleges in the 1980s (Perkins, 2003). Their research documented that misperceptions often exist between what most students think their peers are doing with alcohol—and other drugs, sexual practices, support for collegiate policies, and other issues as well—and the actual norms for their peer group. The quintessential focus of a social norms marketing campaign is an effort to publicly alert specific groups of students to the inaccuracies that exist in their perceptions of normative behavior for their peer group and permissiveness of personal attitude toward peer substance use and the documented reality. In essence, the intent of the strategy is to re-center personal perceptions around the actual peer group norm. This approach to prevention has become a popular way to approach the seemingly intractable problem of high-risk or dangerous collegiate drinking.

The tipping point for this model of prevention occurred in the early to mid

1990s, and the approach became more popular during the ensuing decade. Although anecdotal reports of the strategy's effectiveness began to surface with regularity, empirical evidence regarding its efficacy is only now surfacing in the literature. That said, the anecdotal evidence and preliminary quantitative research on the prevention model led the National Institute on Alcohol Abuse and Alcoholism to rank the social norms approach as a Tier 3 prevention strategy, or one of the *Promising Strategies That Require Research* (National Institute on Alcohol Abuse and Alcoholism, 2005).

As awareness of the social norms model grew and anecdotal evidence of success began to be reported, professionals started to view the model with greater respect. With wider use came more anecdotal reports of success, which sparked even greater interest. Consequently, many prevention practitioners, health educators, and student affairs professionals in general began see social norms programs as an important arrow in the quiver in the quest to combat the persistent problem of high-risk collegiate drinking.

With this increased interest in and attention to the social norms approach came greater scrutiny from many in higher education. Curiously, however, although most of the attention to social norms has been due to its utility in preventing high-risk or dangerous drinking, little attention has been paid to

its potential for use as a treatment modality with individual students already diagnosed with an alcohol or other substance use disorder. This brief essay will present an argument that social norms theory may represent a strategy that counselors and other treatment professionals may wish to consider as they engage clients individually or in groups for counseling.

From Prevention to Treatment

In the late 1990s a paradigmatic shift occurred in how prevention was viewed. No longer were health educators and student affairs professionals simply advocating *primary, secondary and tertiary prevention*, i.e., preventing, intervening, and treating disorders, respectively. Rather, the emphasis began to be placed on conducting prevention efforts with *universal, selective, and indicated* populations. In essence, the field shifted from focusing on *what was done* to *with whom* it was done.

A *universal* population is the general population. In the case of higher education, this would be the entire student body. Some of these students are at risk of engaging in high-risk and dangerous drinking, but most are not. Therefore, these preventive interventions tend to be general, consciousness and awareness-raising activities designed to inform the population about general information, i.e., the *FYI* of prevention (Dimeff et al., 1999).

A *selective* population is a subpopulation of the universal or general population thought to be at risk of engaging in high-

risk or dangerous drinking, e.g., first-year students, members of Greek-lettered organizations, and athletes. These are the students that research has suggested tend to be vulnerable and who show a proclivity towards high-risk behaviors (Dimeff et al., 1999)

An *indicated* population is one already showing signs of having developed a problem. These are students with multiple alcohol or other drug violations or individuals who already display indications of difficulties that result from personal choices, e.g., individuals with legal, social, academic, familial, or health-related consequences related to their alcohol or other drug use (Dimeff et al.; 1999).

Social norms campaigns have historically targeted all students on a campus, i.e., the *universal* population. Such campaigns can also be adapted to address misperceptions about the normative attitudes and behavior of peers and applied effectively with selective populations, as when social norms marketing is targeted at certain subpopulations, such as first-year students or athletes. Working with an indicated population, however, presents a somewhat more challenging group to reach with social norms techniques. Although campaigns have been mounted to address populations (like Greek letter organizations) known to have a proclivity for high-risk behavior, the use of social norms as a treatment tool in individual and group counseling with students recognized as having a substance use disorder has yet to become widely practiced. To understand how social norms (SN) strategies can be

effective treatment tools we must first understand the basic underpinnings of effective interventions with students engaging in high-risk behaviors.

Motivating Change

Now classic research suggests that individuals that change their behavior—frequently on their own and without benefit of formal treatment—do so by moving along a continuum: from a current, high-risk pattern of behavior to a lower-risk pattern (Prochaska et al., 1994). This continuum is composed of stages of readiness to make change that range from *pre-contemplation* or, in the nomenclature of traditional counseling efforts, *capital “D” denial* where there is no intent of changing behavior in the foreseeable future, and ends with a stage of maintaining the new, lower-risk behavior, what traditional counseling might refer to as *relapse prevention*. Further, we have learned that when stage-appropriate interventions are employed, that is, interventions shown to be effective in motivating movement from the client’s current stage of readiness to change to the next stage on this continuum, steady progress towards lower-risk treatment objectives is noted (Prochaska et al., 1992).

The most challenging clients for any counselor or student affairs professional to engage are the pre-contemplative and contemplative students. These are students who do not believe that their behavior is high-risk let alone a problem, or, if the issue of change has occurred to them—the contemplative student—it has been fleeting and certainly not something they intend to pursue *right*

now. The literature suggests that intervention strategies designed to increase the individual awareness of personal behavior and its consequence and/or raise consciousness about the *cause-and-effect* relationship that exists between short-term choices and longer term outcomes tend to motivate such students movement along the continuum of readiness to change. It is with these clients—the pre-contemplative and contemplative students—that a treatment strategy steeped in SN theory may prove to be quite effective.

So, how do we take a Tier-3 prevention strategy and apply it to the individual or small group as a treatment strategy? It is likely that once practitioners recognize that SN interventions can be effective in motivating students in treatment to move through the earlier stages of readiness to change their high-risk behaviors—be that cigarette smoking, alcohol consumption, or sexual practices—they will individually create techniques to address the misperceptions that their clients hold regarding normative behavior in their immediate and universal peer groups, thereby motivating movement through the stages of change. Here are two specific strategies that may prove useful in employing SN as an approach to treat substance use disorders in students. The first is intended for use with individual clients, while the second can be employed in a small group.

Social Norms and Confirmation Bias

Confirmation bias occurs when one has made a decision or subscribes to a particular belief and then actively looks

for information that will confirm the appropriateness of the decision or belief. Such practices inoculate the individual against facing the dissonance associated with *being wrong*. If a student believes that personal patterns of drinking or smoking are consistent with what *most* normal students are doing, then those individual patterns will not seem inappropriate and the student is prevented from seeing the connection to longer term, detrimental consequences to academic performance or social success. In fact, students in a pre-contemplative stage of readiness to change will seek out those individuals and situations that confirm a fallacious view of normalcy in one's peer group. Old-school addiction counselors speak of changing one's friends in order to maintain desired drinking/using practices as being a symptom of dependence. Steps taken by a counselor that can help students discover the dissonance between their current pattern of behavior and what truly is normal behavior in their peer group may facilitate movement through the stages of readiness to change. In short, as I become more aware that my personal behavior lies *outside* the range of what is considered normal in my peer group, the resulting dissonance is assuaged by moving to the next stage on the continuum of readiness to change.

In this technique, intended for use with individuals—but it may be adapted for use in a small group—ask the client how many large parties are typically hosted on a typical weekend evening around campus, e.g., a Thursday, Friday or Saturday night. Most students will be fairly accurate as they proffer a guess. Next, ask how many students are likely

to be at each one of these events and then do the math: “A” parties multiplied by “B” students = “C” students at parties. Subtract “C” from the total student population matriculated at the institution and ask, “What are the rest of the students doing?” It is not uncommon for the student to respond that the rest are drinking in their room. Acknowledge this and then ask how many students are drinking in their room—most students with whom the author has used this technique have suggested 10 to 15% of the student population. This is probably high, but “run with it” in order to gain credibility in the eyes of the student and encourage the end result to be the product of the student's perceptions of the norms at school. Now, repeat the math exercise and ask, “What are the rest doing?” Again, most students will respond with something like, “Drinking downtown”—remember the role of confirmation bias here as the student struggles to avoid the dissonance associated with being outside the norm. Repeat this process until the student has run out of *places students might be drinking*. Now ask again, “What are the rest of the students doing?”

If you are at a relatively small school, there will be a correspondingly small number of parties, larger schools have more parties, but a larger student body resulting in a relative net similarity in percentages of students at these events. Almost invariably 50 to 60% of the students at the institution are doing something other than drinking on any given night. The result of this observation is that the student is presented with an opportunity to discover that personal perceptions of

who is doing what on any given night may not be accurate. Also, this is likely to set up the student to react differently to other social norms messages that may be encountered on campus as part of an ongoing social norms marketing campaign. In essence, the use of social norms as a treatment strategy may increase the likelihood that the student in treatment is more receptive to SN marketing that is targeting the universal population of the institution.

In Vivo Social Norms

This use of SN as a treatment technique is designed for small groups, between 12 and 25. It can be used as a psycho-educational activity as well as an icebreaker in a group counseling setting. The objective of this activity is to invite pre-contemplative and contemplative students in treatment for high-risk behavior to increase their awareness of the risk associated with their behavior and become more cognizant of that fact that their behavior may be further outside the norm than they think.

This is a spontaneous, brief group survey technique, designed to bring personal misperceptions of the norms in a client peer group to light. Have survey sheets with no more than 4 to 6 simple questions ready to distribute in the group. Design the surveys to reflect the focus of the group, for example, "How often did *members of this group* drink last week?" (smoke-up, have sex, whatever) and "How often did *you* drink last week?" In typical social norms survey style, make sure that the questions you ask are simple, straight forward and present the opportunity to

identify individual perceptions about what each member of the group has done as well as what the individual student has done. You can take an extra step if you choose and actually offer some ranges for each question. For example, for the question, "How often did members of this group drink last week?" you could offer choices like "0," "1," "2 - 3," "4 - 5," "6 or more" or divide the categories in any way you believe will best present you with the opportunity to illustrate the point you wish to make in that particular group. If you know everyone in the group drinks several times every week and you would be happy to see a reduction to 1 or 2 times a week, then you may offer 2 simple categories, "3 or less" and "4 or more": The point being, *you* set the bench marks.

Once the surveys have been completed, collect them. As you are doing this you can make a bit of small talk about what you are going to do next with the surveys, assuring students that their survey results will be anonymous, etc. Then as you continue to talk with the group about what you are doing with this exercise, obviously shuffle the surveys in your hands. After the surveys have been mixed up thoroughly, go around the group and ask each student to take one. Assure them that they are likely to get someone else's survey, but if they get their own, *pretend* it is someone else's. Then ask questions of the group based on the survey each member of the group is holding. For example, if having used the graduated, "How often did members of this group drink last week?" version, ask, "Who has a low number?" "Who has a high number?" This

establishes a range, which is probably going to be quite broad. Ask all those holding a survey where the person who completed it drank “0” times stand up...“1” time...“2.” It is not uncommon that where the perceived norm is 4 or more times a week, half or more of the group may be standing when asking if they drank 2 or less times a week. Again, be creative with the specifics, but this use of a SN strategy opens the door to individuals group members being confronted with the dissonance in their perceptions of the norms.

Processing this exercise is based on allowing members of the group to actually see that their perceptions of the norm may be skewed. Again, the purpose of the exercise is to allow those individuals in a pre-contemplative or contemplative stage of readiness to change to have their beliefs drawn into question, but to do this not so much with a frontal assault of those beliefs, which can breed resistance and resulting resentment, but rather by inviting students to discover the misperceptions they hold.

A variation on this approach can be to employ the “snowball survey” which is used in many social norms campaigns. In such approaches, students are instructed to take the surveys once completed and ball them up into paper “snowballs” and then toss them around the room for a minute or so. Then everyone is invited to pick-up a survey and this essentially satisfies the need to “shuffle” the surveys in the group (Christensen, 2005; Gitchell and Zelezny, 2005). This is likely a bit too cavalier for a formal counseling group,

but the practitioner can make that determination.

Conclusion

Social norms techniques have been around for some time. Their roots are in the social psychological literature of the past 50 years and borrow heavily from the research on social influence. As this approach to preventing high-risk collegiate behavior has gained attention and respect, the question occurs: Can social norms techniques be used to pursue treatment objectives with students diagnosed with substance use disorders? Although this question remains to be answered, it would at least seem plausible that this is possible, hence the argument presented in this essay.

To pursue this issue further, it is recommended that the reader consider the nexus of the literature concerning Motivational Interviewing as a counseling technique, social influence as a phenomenon in social psychology, and social norms as an approach to preventing high-risk student behavior.

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Reminder

The 2006 National Conference on the Social Norms Approach is scheduled for July 26-28, 2006 in Denver, Colorado. The conference will be held at the Grand Hyatt, 1750 Welton Street in Denver.

For registration and other conference information, visit the website of either the BACCHUS and GAMMA Peer Education Network (www.bacchusgamma.org/) or the National Social Norms Resource Center (www.socialnorm.org).

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