David Regis is a Research Fellow with the Schools Health Education Unit.

David Regis

Peer tutoring seems to work — but why?

Is independence from the peer group really desirable?

Peer-led health education for schools is 'in', but recent initiatives appeal more to results than a body of theory. The technique has had a considerable history in the United States, particularly with respect to smoking, and has set seed in this country both in smoking education and in other areas of the curriculum such as alcohol and sexuality education.

In this article I will draw out some of the key issues, as I see them, from the smoking field, although much of what I have to say may apply to education about other health-related behaviours and with groups of people other than school students.

Let me begin by stating a consensus view, which is that *schools health education should be about promoting informed choice*, perhaps even valuing the quality of a decision over its content. (Thus, turning a shallow, conformist non-smoker into an independent, rational and self-aware person who decides to smoke may even be seen as a health education success [Kolbe, 1981].)

In this regard, a central value is placed on *autonomy,* which is in keeping with other work and thought about the general personal and social education of young people in schools (Tones, 1986).

The need to promote autonomy reflects the belief that young people should be able to challenge pressure from their peers to 'conform', particularly if there is peer pressure to smoke or behave in other health-risky ways. For an authoritative account of sociology's current view of the role of peer groups, I turn to the second edition of John Coleman's wide-ranging and perceptive book, *The Nature of Adolescence* (Coleman & Hendry, 1990, p. 11):

> It is commonly assumed by sociologists today . . . that the socialisation of young people is more dependent on the generation than on the family or other social institutions . . . As the individual adolescent begins to grow more independent of his or her family the peer group becomes an important point of reference. It supports independence, meets needs for identity and recognition, presents opportunities for achievement, and affords the opportunity of playing a variety of adult roles.

This surely is also a common view amongst teachers and health care professionals. The body of theory and research built up over the last few decades has led to a more sophisticated view of adolescence, where many conventional views have been called into question (see, for example, Bandura, 1969 & Rutter, 1977), but this central idea of the importance of peer relations has not budged.

As far as health educators are concerned, peers are important for two reasons:

- They are often the inspiration and means by which young people are introduced to and practise health-risky behaviours.
- They may also hold the key to effective health education intervention.

I have elsewhere criticised approaches to health education that have as their goal the fostering of adolescents' self-esteem, in the hope that this will lead to *independence from the peer group and other influences* (Regis, 1990). These strategies ignore the fact that social influences play a part in the fostering of self-esteem to start with, and that the positive functions of the peer group described by Coleman are extremely important.

So I have been very interested in those initiatives which, *far from trying to minimise peer influence in adolescence, make a virtue of it*, and use peers as session leaders for school health education. This article will describe some of these approaches and indicate some difficulties I see in adopting them.

Peers and no-smoking declarations

One of the most distinctive features of recent US intervention research involves the use of other young people the same age as the target group (who may be specially-briefed class members) or perhaps a year or two older to act as discussion leaders (Perry et al., 1980) and the use of video-recordings of individuals' declarations of that they will refrain from smoking.

Peers are naturally a source of support and learning, so why not exploit this?

Evaluation of most of these programmes is by assessment of smoking levels by a self-report questionnaire which may be verified by saliva analysis.

Videos and other materials may be used to stimulate discussion and learning about social pressures (Evans, 1980 & Perry et al., 1986).

Results from these programmes have been enormously encouraging (e.g. Flay et al., 1985), even at long-term follow-up (Murray et al., 1988). In one study (in Murray's paper), 13% of non-smokers in the control groups had started smoking after four years, while the peer-led 'social influences training' group contained only 8% of new smokers — a full 5% difference after four years.

Quite a lot of work of this sort is going on and has produced research papers glowing with pride at their success rates (Best et al., 1984; Murray et al., 1984; Flay et al., 1985; Gilchrist et al., 1985: for a review see Glynn, 1989). However, as Reid (1985) and indeed Evans and Flay have pointed out, some of the work of this sort is not very useful to teachers, for the following reasons among others:

- The programme may have to be delivered by experienced or specially-trained research personnel (as in Botvin et al., 1980).
- There may be a great deal of research hustle and bustle (perhaps inevitably invoking the 'Hawthorne effect') which may distort results (Dielman et al., 1985).
- There may be a need for substantial availability of time or equipment; conversely, the duration of the study may be very short (Flay et al., 1985).
- The institutions selected may not be typical ones — either because they are unusually highly motivated or in other ways different (one study involved the payment of sums of money to the school!).

Positive results under these conditions are significant only in the statistical sense. However, there *are* practical, exportable examples that are impressive and exciting. After all, peers are naturally a source of support and learning, so why not exploit this existing feature of young people's development in the classroom?

Are peers really more effective communicators?

What concerns me more here is: *why does this approach work at all?* The conclusion that peers are superior to adults may be intuitively reasonable, but it was not predicted by researchers, and until we have a theoretical perspective which explains it we cannot claim to understand what is going on. If we understood the process better, we might even improve upon the results. However, some reasons why these interventions work might be uncomfortable.

I will look at some lines of enquiry that might focus more exactly upon the processes that have led to such striking successes.

1. Mechanics of persuasion

I dusted off some old theory on the psychology of persuasion from a classic work by the Yale School (Hovland, Janis & Kelley, 1953). They describe communication as between the source (the peer leader in this case), who delivers a communication to the audience (the class). Persuasion occurs after a multi-stage process as follows:

a. Attention
b. Comprehension
c. Acceptance/yielding.

One might also add (McGuire, 1968):

d. Retention
e. Action.

Let us take these in turn, and I will briefly illustrate how they might provide a recipe for action.

a. Attention
Peers may hold the attention better, particularly if the school rarely uses peer tutoring. Teachers reluctant to use peers might concentrate on this aspect of their work — do we have the attention of our classes?

b. Comprehension
Peers may use a language or mode of delivery more conducive to developing understanding in their audience. Teachers reluctant to use peer tutoring might reflect upon this with profit — can pupils always understand us?

c. Acceptance/yielding
The audience may be more prepared to accept communication from peers just because they are peers. This is discussed further below (2).

Class members may feel more able to raise issues and to talk about matters in quite a different way when peers lead a lesson.

d. Retention
The distinctiveness of the sessions may lead to them being better remembered. Again, this is something all teachers might attend to — could we make our lessons more memorable?

e. Action
The communications of peers may be more likely to be acted upon than those of teachers, perhaps because in a given social situation they are more available or more salient.

2. Nature of the source

Peers may have a credibility advantage, perhaps because they are seen as having nothing to gain themselves, or speaking with greater authority when the topic is peer relations. Again, if this is seen to be the case, teachers' personal and professonal claims to insight might be promoted and advertised to the class.

Peers are perceived as members of a congenial group. They may have an advantage over teachers in this respect, although some individual teachers may have less of a problem than others! Rather than teachers claiming 'group membership', which may be hard to demonstrate, the notion of relative *social distance* may be more useful.

3. Emotional climate

A less mechanical view of these programmes might suggest that peer leadership creates some sort of atmosphere in which attitude change is more likely, or makes attitude towards preferred behaviour more positive. Class members may feel more able to raise issues and to talk about matters in quite a different way when peers lead a lesson — after all, smoking is on other occasions a disciplinary matter for teachers and pupils.

A related point is that peers may be less likely to 'rub the class up the wrong way' — a teacher betraying excessive concern or criticism may create an adverse emotional climate.

It is surely useful if the emotional climate in the room is positive, but perhaps not too positive. I have heard accounts locally about some very exciting and effective Road Safety Education carried out some years ago by a former Road Safety Officer, Graham Williams, who was able to create a tremendous atmosphere of purpose and to promote positive attitudes towards safer road use in primary school children.

Ironically, the other thing I know about Graham's work is that some teachers found it very difficult to accept — because it smacked of 'indoctrination', and conflicted with their commitment to autonomy. Are we worried about this aspect of peer education?

4. Persuasion or indoctrination?

Kelman (1958) divided up mechanisms of any attitude change into three types:

- Compliance due to hopes or fears unconnected with the content of the communication.
- Identification with a source.
- Internalisation, where the source's values become the audience's own.

This scheme may help explain why the class members may be more likely to accept things from peers. They may be more *compliant* to their direction, they may *identify* with them and thereby adopt their attitudes, or they may more readily *internalise* material learned from peers.

However, *compliance*, if it occurs in these classes, will clash directly with the notion of autonomy.

Medics use 'compliance' in a technical sense to include client adoption of recommendations, however this might occur. In Kelman's sense, however, 'compliance' means a conformity to direction that amounts to 'giving in'.

Nevertheless, one of the things that struck me when looking through examples of programmes (e.g. Perry et al., 1986) was not the differences between the philosophies of using peers or teachers as leaders in the classroom, but the similarities. The approach of these lessons does often include knowledge, attitude identification, and so on, but also a component that is specifi-

cally about *resisting peer pressure*.

Isn't there something a little odd about trying to use young people's *susceptibility* to peer influence in these programmes, when *resistance* to social influence from peers is at least part of the message? For example, Perry et al. (1986) have a lesson called *No, No, a Thousand Times No!* which is about peer influence, and the UK peer-led smoking package *Smoking and Me* (Gammage et al., 1990) also includes a lesson on 'How to say No'.

This is a type of homeopathy, where a little of the poison of peer influence is used to attempt the cure. In the rush of recent initiatives in peer-led health education, should we temper our new enthusiasm for peer influence with our previous hostility to it? I think that until we know a little more about how and why they work, peer-led programmes may still need handling with care.

Acknowledgements

I would like to thank Elspeth Gray of Bristol University for her helpful comments at an early stage of my thinking. She, of course, bears no responsibility for remaining misconceptions.

I also valued greatly suggestions made by John Balding, Director of the SHEU, and Kath Wilson, Advisory Teacher for Somerset Health Authority.

References

Bandura, A. (1969). The stormy decade: fact or fiction? In Rogers, D (ed.): *Issues in adolescent psychology*. New York: Appleton Century Crofts.

Best, J. A. et al. (1984). Smoking prevention and the concept of risk. *Journal of Applied Social Psychology*, 14, 3, 257-273.

Botvin, G. J. et al. (1980). Preventing smoking onset through lifeskills training. *Preventative Medicine*, 9, 135-143.

Coleman, J. & Hendry, L. (1990). *The Nature of Adolescence* (2nd edition). London: Routledge.

Dielman, T. E. et al. (1985). Fifteen-month follow-up results of an elementary school-based prevention project: 'resisting pressures to smoke'. *HYGIE*, 4, 4, 28-35.

Evans, R. I. (1980). Behavioural medicine: a new applied challenge to social psychologists. In Bickman, L. (ed.): *Applied Social Psychology Annual* Vol. 1. Beverley Hills, CA: Sage.

Flay, B. et al. (1985). Are social-psychological smoking prevention programs effective? The Waterloo study. *Journal of Behavioural Medicine*, 8, 1, 37-59.

Gammage, E. et al. (1990). *Smoking and Me*. London: HEA.

Gilchrist, L. D. et al. (1985). The relationship of cognitive and behavioural skills to adolescent tobacco smoking. *Journal of School Health*, 55, 4, 132-134.

Glynn, T. J. et al. (1989). Essential elements of school-based smoking prevention programmes. *Journal of School Health*, 59, 5, 181-188.

Hovland, C., Janis, I. & Kelley, H. H. (1953). *Communication & persuasion*. Yale University Press.

Kelman, H. (1958). Compliance, identification and internalisation: three processes of attitude change. *Journal of Conflict Resolution*, 2, 51-60.

Kolbe, L. (1981). Propositions for an alternative and complementary health education paradigm. *Health Education*, May-June, 24-30.

McGuire, W. J. (1968). The effectiveness of supportive refutational defenses in immunising and restoring beliefs against persuasion. *Sociometry*, 24, 184-197.

Murray, D. M., et al. (1984). The prevention of cigarette smoking in children: a comparison of four strategies. *Journal of Applied Social Psychology*, 14, 3, 274-288.

Murray, D. M. et al. (1988). Four- and five-year follow-up results from four seveth-grade smoking prevention strategies. *Journal of Behavioural Medicine*, 6, 53-62.

Perry, C. L. et al. (1980). Adolescent smoking: a third-year follow-up. *World Smoking and Health*, 5, 40-45.

Perry, C. L. et al. (1986). A process evaluation study of peer leaders in health education. *Journal of School Health*, 56, 2, 62-67.

Regis, D. (1990). Critical note: on the concept of self in health education. *Pastoral Care in Education*, 9, 1, 7-9.

Reid, D. (1985). Prevention of smoking amongst schoolchildren: recommendations for policy development. *Health Education Journal*, 44, 1, 3-8.

Rutter, M. (1977). Adolescent turmoil: fact or fiction? *Journal of Child Psychology and Psychiatry*, 17, 35-36.

Tones, B. K. (1986). Promoting the health of young people: the role of personal and social education. *Health Education Journal*, 45, 1, 14-19.

Version 18 of the Health Related Behaviour Questionnaire.
Pick and mix to your requirements!