

Conformity, consistency, and control

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One theory of education suggests that youngsters who behave in health-risky ways ignore what they 'really' know about the dangers; they ignore these dangers because they give in to social pressures; they give in to social pressures because they do not feel at ease with themselves or the world. These ideas are familiar to most teachers and health-education workers, but this paper presents evidence to cast doubt upon each of them.

Introduction

I came to the Schools Health Education Unit in 1986 to begin work for a Ph.D. Before arrival I worked as a teacher of biology, and I suspect like many beginning teachers of biology took a rather evangelical approach towards those areas of the biology which are relevant to the health of the students in my classes. If only (I thought) I could explain the dangers of smoking to them clearly enough, surely they would then refrain from smoking? I am sure I am not the only teacher to have had 30 passably articulate accounts of the dangers of smoking displaying good understanding of the issues returned by a class which contained a majority of smokers. In fact, this happened to me in my first period of teaching as a trainee teacher.

My faith in what I have since learned to call the 'medical model' of health education (Fig. 1) never recovered from this blow; others, for example Reid (1986), have rebutted it more formally. However, I couldn't find anything very satisfactory to replace it. Once I turned from simple information-giving I entered a tangled mess of other theories, all of

which I could give some credence to but none which I could define very clearly. My initial reading rapidly convinced me that I had bitten off more than I could chew; I shrank before the endless lists of factors which previous workers insisted were relevant.

However, I became attracted to a model (Ajzen & Fishbein, 1980) proposing that the main determining factors influencing a person's behaviour are the competing influences of their own *attitude* and a measure of *social approval*. The measuring is done using a carefully-constructed questionnaire. This Fishbein-Ajzen model has been used extensively, though mainly in America, and in this article I shall use my work with the model to discuss three factors concerning influence on an individual's behaviour under the headings *Conformity, Consistency, and Control*.

The Fishbein-Ajzen (1980) model of Reasoned Behaviour had a number of things to recommend it: it appeared to be highly successful in predicting people's behaviour, it provided a neat package of methodology which I felt I could understand, it took into consideration most of

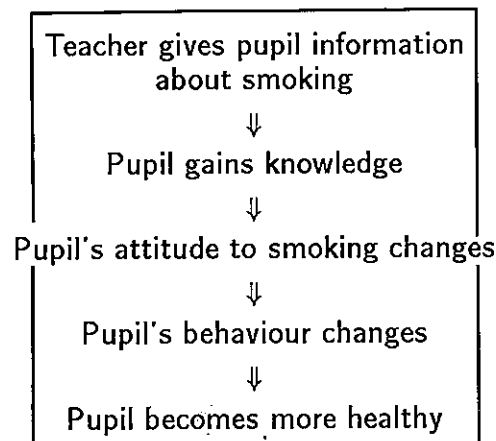


Figure 1. The 'medical model' of health education.

the directly important factors, and most appealingly it provided a clear way of conceptualising the conflict (as I saw it) between an individual's belief system and the influence of people around them.

Ajzen & Fishbein assume that people are essentially rational and not motivated in their doings by mysterious unconscious forces; they also assume that all the principal elements of a decision made by an individual are known to that individual and can be reported by them. For details, the reference above should be consulted.

Conformity

Social influence is a familiar notion in both health education and psychology; many teachers are aware of at least some of the plethora of materials available for teachers who wish to assist their pupils in gaining insights into social processes involved in health-related decisions, leading to the acquisition of the social skills required to resist social pressure. The table on page 100 of the last issue of *Education & Health* concerning expressed preferences for topics to be included in the curriculum also stands in testimony to the importance of PSE.

It is also a strong theme of health-education literature that *self-esteem* is relevant to the influence of social pressures on health-related decisions. One may cite Bynner's classic smoking study

(Bynner, 1969) and John Balding's work at the Schools Health Education Unit. The link is certainly there: what is less clear is how the link is formed.

The idea that youngsters of low self-esteem are less inclined or less able to resist social pressure to behave in health-risky ways goes back a number of years. Asch's (1955) classic experiments seemed to show that in carefully-staged situations where people were subjected to really rather mild social influence, some 25% of his subjects were prepared to deny the evidence of their own eyes in order to agree with the rest of a group. Later experiments showed an apparently clear link between this conforming behaviour and low self-esteem. Among other authorities, Burns (1979) cites without demur an old 1954 reference which purportedly shows a greater resistance to influence of high self-esteem subjects, while Janis (1953) is another widely-cited reference which claims the same.

Not unnaturally, this was one of the first things I thought to investigate with my own data; in terms of the Fishbein-Ajzen model, subjects with low self-esteem subjects, or subjects with an otherwise poor self-concept, should show a greater susceptibility to social pressure. I performed a regression analysis, attempting to predict smoking and drinking intentions from calculated measures of attitude and of social pressure, and the most important results are summarised in Table 1 (overleaf).

Table 1 caused me a lot of concern. I performed a series of regression analyses to examine the relative influence of their own attitude and of social approval upon an individual's smoking and drinking intentions. I then repeated the analysis to see if pupils with a poor self-concept — low self-esteem, external locus of control (see below), or both — differed from other pupils in their year group who had a more positive view of themselves; naturally, I expected pupils with, for example, low self-esteem to be more influenced by social considerations. In the table, + and - signs indicate a greater or lesser influence respectively, compared with pupils having a better self-concept,

Group	Year	Smoking		Drinking	
		Social pressure	Attitude	Social pressure	Attitude
External locus of control [ELOC]	4				
	3	-			+
	2		+	-	
Low self-esteem [LSE]	4	-			
	3		+		
	2	-		-	+
Poor self-concept [ELOC and LSE]	4	-			
	3	-		- *	
	2		+		+

Table 1. Compared with whole-group data, do pupils with poor self-esteem have better (+) or worse (-) relationships between attitudes or social influence and their intentions? ($p < 0.05$, $*p < 0.55$.)

and it will be seen that attitude rather than social pressure exhibits the positive association.

I was most perturbed; in other words, I suspected I would be subjected to no little social influence myself! In the time-honoured fashion of Ph.D. students the world over, I had done my experiment first without much careful examination of the literature. Had I done so, I might have prepared myself more ably for such a set of results. In fact, as far as I can tell, Burns' reference in the work cited above does not exist, and the simple notion that low self-esteem is a factor predisposing to conformity had already been shown to be at least open to question (Wallace, 1983) — something I found surprising, given the number of times this assertion is made (often without argument) in educational literature; readers of this article may unwittingly have been led to a similarly uncritical view.

A moment's reflection may provide a way of reconciling these results with common sense. In certain sorts of contrived situation such as those Asch and Janis studied, high self-esteem may well be useful in resisting the persuasions of others. However, it is easy to think of

examples in everyday situations when it is not necessarily irrational to conform, despite one's own beliefs: if everyone around me disagreed with my particular interpretation of a set of results, would I be sensible to ignore them?

Furthermore, it is important to consider the sources of good self-concept. Is it developed (a) through standing nobly aloof from the ideas and practices of family and friends, or will it be better fostered (b) by repeated events demonstrating an alignment between personal behaviour and what family and friends favour? The theory that low self-esteem leads to conformity sits uneasily against the evidence from my own and others' research which suggests that conformity can lead to enhancement of self-esteem!

Sheppard *et al* (1983) too, in their provocatively titled paper, would question some of the assumptions underlying the 'social skills' approach to health education; Hopkins (1988) further concludes that social psychology must deny that 'influence represents weakness', and later adds that *Conformity to social pressure is wholly inadequate to explain patterns of health-related behaviour in adolescence.*

Consistency

Health education workers and psychologists alike have been interested in the question of consistency. As noted above, I have been troubled by the 'inconsistency' of my smoking pupils for as long as I have taught — smokers often acknowledge to a greater or lesser degree the health dangers of smoking.

Fishbein (1977) suggests two responses to help those who wonder how important this sort of apparent inconsistency is. Firstly, it needs to be established whether the individual smoker genuinely feels that they *personally* are at risk from the smoking that they do — or if 'it'll never happen to me'. My data would indicate that youngsters are aware that it could; 4th-year smokers do tend to agree with a personally-worded statement on the dangers of smoking, although less so than their cleaner-living classmates.

Fishbein would also ask how remarkable this inconsistency is; after all, we are presented with complex and often contradictory information about our behaviour from all sides. As regards smoking or drinking, health is not the only, or even the prime, consideration in forming decisions. Not the least of these other factors may be the individual's standing in a social group.

Control

Another key issue in health education is the notion of perceived control. Many youngsters may feel at times that during their school years they are on a conveyor belt, and one whose speed and destination are outside their control. Some may rebel against control by authority figures, but many give in. Less generally, they may also feel similarly helpless about their health; experiences within their families or experiences of their problematically changing bodies may lead them to the view that there isn't a lot of point struggling to keep themselves healthy when clearly so much of health is out of their control.

In view of this, it is a frequently-cited goal of health education in all spheres and of much PSE that educators should strive to put individuals 'in control' of

their lives, and to foster in those individuals a sense of power over their health and their lives generally. Research has shown the relevance of individuals' perceptions of control to the actions they take (or fail to take) in regard to their health (Wallston & Wallston, 1980 and Lawrence, 1984).

The concept of *locus of control* seemed a useful way of tackling this factor. Locus of control refers to the extent to which individuals perceive themselves as being in control of (and thus responsible for) the course of events which they experience: in its original conception it was measured on a scale from *fully internal* (the person feels fully in control of their life) to *fully external* (the person feels completely out of control of their life).

In scales designed to measure health locus of control, Wallston & Wallston (1980) proposed three distinct components: Internal, Chance, and Powerful Others. I examined the influence of perceived control in my study using modified versions of this scale. In my own questionnaire, adapted to work with youngsters in the UK, an example of a statement to measure Internal locus is *Whatever goes wrong with my health is my own fault*; similarly, a sample Chance statement is *When I stay healthy, that just means I've been lucky*; and a Powerful Others item could be *Doing just what the doctor tells me is the best way to stay healthy*. (Respondents had to indicate whether and how strongly they agreed or disagreed with these and other statements.)

This aspect of self-concept, as shown in Table 1, shows a similar pattern of results to self-esteem when examining the balance between the influence of attitude and social pressure on behaviour, and may do so for similar reasons; thus, repeated social approval fosters both an improvement of self-concept and a reinforcement of socially-consistent behaviour.

It is a striking feature of my data that *smokers and non-smokers differ markedly in their conceptions of their health locus of control*. For example, 4th-year smokers show a markedly greater belief

in the uncontrollability of health, having a distinctly higher Chance Locus of Control.* This then raises the question once more of whether smokers *are* being genuinely inconsistent. Rather than arguing "It'll never happen to me", my subjects seem to be suggesting that although it might happen to them, there's no point doing much about it, because "if the smoking doesn't get you then something else will". This result certainly argues quite strongly against the mere repetition of health warnings about smoking; all this may achieve is increasing anxiety amongst smokers!

It isn't clear which comes first, the smoking or the perceived lack of control. For example, changes in perceived locus of control occur in all types of subject over the years examined (ages 12-15) whether they smoke or not, so it may be that those who develop a belief in their lack of control over their health are then tempted into smoking. Conversely, in response to repeated challenges about the dangers of smoking from others (or indeed from each packet they buy) young smokers may come to adopt this belief in order to defend their consistency — or perhaps just to get people who nag them (like biology teachers) off their back.

Conclusion

I have tried to make clear in the text above where I think my findings have implications for the practice of health education, and have defended a particular view of it; perhaps the only other thing I am concerned to defend (having been challenged on this point several times!) is the usefulness of this sort of research. My aim in so doing is not to bully teachers with their ignorance of theory, but to argue for its importance. Collins (1984) has distinguished 19 distinct theories implicit in the language of teachers and others concerning the best way to do

*The difference between 4th-year smokers and non-smokers with respect to their health locus of control was remarkable: a T-test for significance of mean scores from 271 pupils gave $p < 0.0004$, an almost unheard-of value in this kind of research.

health education. Moreover, she showed that any individual teacher may favour words which properly belong to different, even contradictory, perspectives.

I do wonder if iron consistency is a very worthwhile goal — education has many aims, not all of which can be quickly reconciled with each other, and the best way of educating one pupil need not be the same way as for another; teaching is too complicated a job to be reduced to a single theory. But I would argue that teachers would do well to reflect upon their own practice, lest they proceed blindly (though I should add that I have never met a teacher who was not articulate about what they were doing and why). My own experience also suggests the value of reflecting upon how much you prefer to trust the advice given in glossy packages; or indeed in articles such as this.

I would like to thank publicly all the members of staff of local schools and of the SHEU who have helped me with my work, who have shown me unfailing generosity in giving up their own time and without whom my work would not have been possible.

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Review

Coping with conflict by F. M. Nicholas. Living & Learning (Cambridge) Ltd, 1987: 163 pages, £9.95. ISBN 0 905114 26 4. The origins of this book, in the publishers' *Learning Development Aids* series, lie in a resource pack developed by a Norwich Teachers' Centre group and subsequently modified and re-written for the present publication. For those experienced in World Studies, Development and Peace Education the first few pages will prompt the question 'What's new?', since most of the activities have been described in earlier books. A great variety of sources have

been used to compile a sequence of strategies focussed here upon the theme of conflict.

Within this framework there are four sections — *Small World; Wider World; Others' Worlds; Our World*. Units of work include: 'Looking at the world through newspapers' and 'Television, conflict and violence'. Each section is introduced with notes for the teacher and advice on further resources, whilst the description of the strategies includes some copyright-free material. The quality of presentation is generally good, the guidelines having the virtues of brevity and clarity, but some of the resource sheets could pose problems for the middle school pupils for which the book is intended. At times the author's caveat about age-range might be enlarged into a strong reservation that, in the form suggested, some of the activities would be more successful and justifiable with upper school pupils.

The author expects that the book will contribute ideas to both integrated and traditional subject programmes, although it would seem well suited to use within PSM courses. No doubt most teachers will adopt a 'pick and mix' approach although the hope is expressed that *by the time they have worked through the book, children will have a greater understanding of the consequences of violence and the possibilities of non-violence; also that they will feel confident in their potential to bring about change and influence their own future*. Since the systematic use of the book is unlikely, it would be useful to have suggestions for subject-teachers in particular on the scope for integrating some of the recommended activities within established courses. But that in itself might be thought a contradiction and invites the broader question of how well the book might fulfil the author's grander aim. It implies a commitment to a process of education which is substantially more than the content it offers. Yet it is practical, it will provide some stimulating and worthwhile experiences for the students — and one does have to start somewhere!

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