Differential patterns of substance abuse among hospitalized and non-hospitalized teenagers: peer pressure and self-esteem

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The overall purpose of this research study was to fill large gaps in the knowledge base of social workers concerning substance abusing hospitalized teenagers. To attain this objective, the researcher provided some descriptive data of the substance abusing teenager and respond to the prevalence of drug abuse at all socioeconomic levels, recognizing the demands for social workers to enhance their knowledge base, skills and intervention strategies for treatment of this growing population. The targeted population for the study included adolescents ages ranging from 13 to 17 years old, who experiences all of the psychosocial and ecological factors related to adolescent drug use.
The type of research employed was an exploratory descriptive study, designed to investigate two issues: (1) peer pressure and (2) self-esteem of the adolescents hospitalized and not hospitalized. A questionnaire was administered to 10 males and 10 females, each from a treatment facility and community church. The researcher hypothesized that there is no significant difference in the self-esteem of adolescents who are hospitalized and not hospitalized and that there's no significant difference in peer pressure among hospitalized substance abusing teenagers and non hospitalized teenagers. The null hypotheses were accepted that there is no significant difference between the two groups self-esteem, and peer pressure influence.
DIFFERENTIAL PATTERNS OF SUBSTANCE ABUSE AMONG
HOSPITALIZED AND NON HOSPITALIZED TEENAGERS:
PEER PRESSURE AND SELF-ESTEEM

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
DEBORAH ELAINE SILLS

SCHOOL OF SOCIAL WORK

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ACKNOWLEDGEMENTS

I would like to thank my family and friends for all the moral support given to me during my time of need. First and foremost, a special thanks is given to God for seeing me through the School of Social Work and completing this thesis. Another acknowledgement will go out to Laurel Heights Hospital and Kelly Chapel United Methodist Church's youth department, for granting me the privilege to administer my instrument. Finally, I would like to thank my thesis advisor for all the guidance and support.
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CHAPTER ONE

INTRODUCTION

Substance abuse is not new to social workers. Social workers have an awareness of substance abuse among teenagers. It is remarkable that in the face of so much interest and concern about substance abuse among teenagers so little is known about the psychological, social and cultural aspects of substance abuse, and even less about the methods of helping the substance abusing hospitalized teenager overcome his or her problem.

In order to influence this young population so that they engage in lower risk taking behaviors, social workers need to revisit those differential patterns of substance abuse among this population. The focus of this limited study is on peer relations and self-esteem. In order to influence this population, social workers need to reach these teenagers before peer group influence has become strong and in a manner so as to encourage healthful individuality. Otherwise, their attempts to prove
their individuality may result in increase drug risk taking behavior.

Adolescence is characterized by the need to explore many facets of life and by a sense of invulnerability, the "it happens to others, not to me" approach to life. This combination of experimentation and perceived invulnerability makes it more likely that adolescents will engage in high risk behaviors. Social workers recognize that this risk taking behavior presents extremely grave social and health threats to teenagers. An interesting aspect in the adolescent's striving for adulthood is the conflict between the need for individuality and the need to behave in a manner consistent with one's peers.

Often substance abusing teenagers do not recognize or accept that they are drug dependent. Even those who recognize their dependency may not perceive or want to face the effects that drugs have on their lives and the lives of those close to them. Social workers need to stress prevention with adolescents because of sex and drug experimentation. Social workers are becoming increasingly aware of
sociocultural factors influence on adolescent development. Social class, education, race, ethnicity, sex and place of residence strongly influence the life cycle of the adolescent and the family. It is common knowledge that adolescents who grow up in cities tend to be less dependent on their families for recreation. With public transportation and a greater concentration of recreational options, their potential for independent activity increases. This may increase the distance between parents and adolescents and escalate the normal conflicts of that stage of perceived invulnerability. This is a key concept for social workers to come to appreciate.

Certainly, the problems presented by adolescents with substance abusing behavior vary in severity and duration. It is extremely important for persons working with young Blacks from multi-problem families to understand that these teenagers have little time to develop the skills essential to negotiating intimate relationships successfully, the emotional concomitants of poverty fail to support relationship, according to (Hines, 1982; Gibbs, 1984).
In addition, adolescent experimentations (drugs and sex) is likely to be quickly replaced by parental responsibility. The Black adolescent male, because of limited job options and dismal odds for being able to fulfill the functions of adult males in this society, often becomes a transient figure in his heterosexual relationships. Consequently, he asserts his masculinity by serving a procreative function but frequently cannot go beyond this point. Drugs become so entrenched among this population and substantially increase risk of arrest and imprisonment, physical and mental illness, and death by overdosing (Grandassy, Williams and Harwood, 1980). Drug use among Black youth is highly correlated to low school achievement, delinquency, and accidental deaths. Certainly, social workers need to consider the possible effects of membership in a minority culture on both sexual and drug abuse among their clients.

STATEMENT OF THE PROBLEM

The problems presented to social workers by adolescents with substance abusing behaviors vary in severity and duration. Social workers assessing how teenagers cope with developmental tasks is crucial to
understanding the differential patterns of substance abusing behavior of the teenager. To diagnose what the teenager presents, social workers must broaden their perspective to consider not only the multiple ways in which teenagers function, but also external factors that have an impact on them.

Chemically dependent teenagers have certain characteristics that suggest that social workers explore issues of peer influences and self-esteem. Substance abuse among teenagers is a problem of epidemic proportions and one that no social worker can avoid treating. Social workers represent a major channel for providing accurate information, helping to assess risks, and counseling to actively reduce risk to the adolescent.

Drug use for many low-income Black youth is particularly problematic because it is often linked to a larger life-style that includes delinquency and selling drugs (Brunswick and Messeri, 1986). Consequently, when these youth are referred for treatment, they are usually involuntary clients with multiple social, behavioral, and psychological problems, including low self-esteem, impulsiveness,
high levels of anger and hostility, psychosomatic symptoms, depression, and suicidal behaviors (Beschner and Friedman, 1986; Halikas, Darvish, and Rimmer, 1976, Lee, 1983). Social workers must recognize the impact of the social and political environment on these youth, as well as the culturally patterned coping strategies and defensive behaviors they have developed in response to their chronic levels of environment stress (Franklin 1982). Black teenagers who have experienced a severe trauma or have decompensated because of drugs may present with extreme anxiety. It is important for social workers to do follow-up counseling to help them to deal with their feelings of anger, shame, low self-esteem, worthlessness, helplessness and despair. Social workers must have the skills, knowledge and strategies to intervene in a number of systems that impinge on the lives of Black adolescents, including peers, family, parental influences, the school, the work place, the juvenile justice system and the social welfare system. In effect, social workers are being challenge to demonstrate in concrete action
their responsibility to the substance abusing teenager.

SIGNIFICANCE OF THE STUDY/PURPOSE

Clearly, drugs and alcohol use need some further empirical examination by social workers to obtain an appropriate perspective on their use as part of the syndrome of conditions identifying the adolescent as being diversely impacted by substance use. According to DeAnda (1987), data conflict on the proportion of the youth population for which substance abuse is an issue.

If social workers are to develop meaningful prevention and intervention strategies, more attention needs to be given to the processes that influence the acts of initiating and continuing drug use to a problematic degree. An essential point which social workers must be concerned with is the linkage between substance involvement and economic activities in the lives of young African American substance users - drug use as drug trade. Jessor (1985) calls our attention to this significant factor - that adolescents who abuse alcohol appear to
engage in a syndrome of deviant behavior that includes delinquent behavior and drug use.

Social workers must consider that magnitude of this problem for the African American community. Minority youth are differentially affected by substance abusing behavior, so that social workers will need to consider the specific needs of minority youth in their work. Although cultural characteristics and attitudes vary from locale to locale, it is significant enough for social workers to examine some of the factors that may result in a potential higher risk for African American youth. Concerns about drug use is not new to the social work profession. However, the problem is very complex. Social workers will have to attempt to establish an interpersonal rapport with the drug abusing adolescent. Hopefully, the social worker will be successful in inducing what sometimes appears to be highly resistant and distrusting adolescent, to look for deeper issues that are contributing to the self-destructive drug abusing behavior.

The purpose of this significant study is to fill large gaps in the knowledge base of social workers
concerning substance abusing hospitalized teenagers. This study will provide some descriptive data of the substance abusing teenager and respond to the prevalence of drug abuse at all socioeconomic levels, recognizing the demands for social workers to enhance their knowledge base, skills and intervention strategies for treatment of this growing population.
CHAPTER TWO

REVIEW OF LITERATURE

As social workers, we view adolescence as a developmental period. Adolescence is not a crisis in one’s development. It is a period of human growth that labors under heavy burdens, and is characterized by considerable distress and mental anguish. Unless there is adequate preparation for handling these heavy burdens, the presence of undue stress will result in a breakdown of the individual’s adjustment.

According to Litt (1970), the 1960’s saw widespread destructive behavior by American youth on the streets and on the campuses. Adolescent drug abusers commonly do not come in contact with treatment personally until their behavior has presented to the point that it is recognized by family, school, or legal authorities or they suffer a complication of the drug taking. Lee (1983) asserts that drug abuse appears to have intensified among adolescents. Millman and Khuri (1981) suggest that the adolescent often perceive their drug taking behavior as enjoyable, safe and under control.
In the same context, Fishburn, Abelson, Cisin (1982) state that the relatively high rates of the use of illicit drugs was found among teenagers. They identified that use of ten categories of drug use by youths ages 12 to 17: (1) alcohol; (2) marijuana/hashish; (3) inhalants; (4) hallucinogens; (5) cocaine; (6) heroin, and non-medical use of (7) sedatives; (8) tranquilizers; (9) stimulants, and (10) analgesics.

The profession of social work does recognize drug abuse as a serious problem among a segment of the adolescent population. Now it should be clear that empirical data on the proportion of the youth population for which this is an issue is highly controversial. Social workers must be mindful of the fact that peer pressure and a sense of hopelessness among poor youth can result in IV drug abuse in order to maintain distance from the constant negativity of life or to maintain status in the subculture. The "macho" attitude of the proof of manliness through drug abuse and the need of many young women to comply with their partners demands further increase the risk of destructive behavior, Gibbs (1988).
Substance abuse, including intravenous use, is widely practiced by young people, according to Nurco, Cisnin and Balter (1982). They estimate that there are several million recreational/regular users of cocaine and heroin, and a significant number are under the age of 21. In surveys conducted, for example, over one percent of high school seniors report having used heroin. Of individuals who seek treatment for a drug problem, more than 80 percent report administering drugs themselves intravenously during the year before treatment. Of these, nearly 10 percent are under the age 21.

Social workers are aware that one begins to experiment with drugs at an early age. Reports indicate that the median age for first use of drugs other than alcohol and cigarettes in a population of young males is between 17 and 22. In a treated population of narcotic addicts, the median age for first drug use was 15.6 years. The belief is firmly held that such early drug use is often a significant factor eventually leading to IV drug use. At a minimum, this level of drug use activity at such an age could likely contribute to a weakened immune
system and/or impaired judgment during sexual activity (Nurco, Cisnin, and Balter, 1982).

One million teens run away each year. Of these, nearly 75 percent become involved in drug use, trafficking, and/or prostitution. Again, opportunities to reach this at-risk population through traditional educational methods are unlikely to be successful (Haffner, 1987). Clearly social workers must understand yet another critical reason why substance abuse among adolescents must be curtailed. However, many barriers exist in effecting the necessary changes in behavior among youth with respect to drug use in general, and these are now complicated by the advent of HIV. Certainly, only through a careful analysis of some of these major carriers can social workers move to develop effective strategy of intervention. As social workers we must reflect on the numerous barriers that exist in educating a drug using population. Unfortunately, knowledge alone does not seem to be a sufficient motivator to eradicate risk behavior among drug abusing adolescents.
Solow and Cooper (1974) suggest that the point of crisis for the family is that in which families find themselves because of their drug-taking adolescent. They view the use of drugs as part of a developmental problem of the adolescent. In a study of drug-taking male adolescents, Hartmann (1969) stressed defects in ego and development, intolerance for frustration and pain mood into a high one, and lack of satisfying early object relations and affectionate and meaningful present object relations. It is critical for social workers to understand that the adolescent’s attempt to overcome these lacks through pseudocloseness and fusion with other drug takers during their common experience.

Wieder and Kaplan (1969) noted that the adolescent is particularly vulnerable to drugs, since they hold out the promise of magic alleviation of his/her distress. The adolescent struggles with the biological upsurge of the sex drive and the regressive resurgence of unresolved childhood conflicts such as; fears and wishes which temporarily threaten loss of social adaptation, sublimations, rationality, and maturity. Social workers must come
to recognize that individuals who either start drugs in early adolescence or who perpetuate conflict resolution with them have already, because of structural deficits originating in early childhood, manifest greater disorganization than is usual in the course of the adolescent process.

Other studies suggest that the problem in these families with drug abusing youngsters was not poor communication but rather faulty communication between adolescents and parent. This faulty method had developed because the need to deceive and to be deceived had been chosen as a way of allowing beginning separation. Social workers must be cognizant however, that this faulty method perpetuated poor impulse control and over closeness to parents which may also drive the adolescent into acting-out behavior. Robertson (1989) provides a tool for assessing alcohol misuse in adolescence. He notes that an increase in the social and personal problems of adolescents who abuse alcohol necessitates social worker intervention to help prevent the development of more serious life problems. This instrument is a screening tool that
should be complemented with a detailed social history to ensure that assessment is tailored to a specific adolescent, and a review of pertinent biopsychosocial factors that are associated with alcohol misuse in adolescence.

According to Mayer and Filstead (1979, 1980) an adolescent may be categorized as a nonuser/normal user; misuser, and abuser, or alcohol dependent. They have suggested that a problem user is either a misuser or an abuser. An adolescent alcohol misuser is a person who drinks to the extent that it interferes with anyone or a combination of family living, social relations, and psychological functioning. Effective prevention and treatment of adolescent alcohol misuse requires that social workers be able to identify three factors in the assessment; (1) personal, (2) family, (3) peer or social, Robertson, (1989).

Halebsky (1987) notes that there has been considerable research regarding effects of peer and parent drug use on substance abuse by the adolescent. A correlation has been shown to exist between parent usage and increased adolescent substance abuse.
Kandel and Faust (1975) provide further support to this view. They examine stages of substance use and the influence of parents and peers. Parenting behavior has been shown to have an effect on adolescent drug use (Foster, 1984-1985; Kandel, 1982).

Thorne and DeBlassie's (1985) review of the literature found "one of six teenagers suffer from a severe addiction problem." It has been found that parents and peers have a significant impact on adolescents' behavior (Brittain, 1963; Bandura, 1977), and the focus of several other studies has been on the influence of parents and peers on adolescent's substance abuse. Tudor, Peterson and Elifson, 1980, in a study of 600 high school students showed the relationship with parents are of paramount importance. The influence of siblings on adolescent drug usage has been noted in a number of studies. Foster (1984-1985) found older sibling drug usage increase younger adolescent drug usage. Also noted that the first influence on alcohol, marijuana, and substance usage was the parents, and the second strongest influence was peers.
Obermeir (1989) maintains that the incidence of chemical dependency during adolescent growth halts the developmental process, resulting in arrested socio-emotional development and persistent immaturity. Barton and Dubber (1982) note that the chemically dependent adolescents are low in self-esteem, lack good coping skills and a deficient in problem-solving techniques.

Walfish, Massey and Krone (1990) noted that the major reasons for substance use are related to tension reduction/coping, the actual effect of the drug, and a peer-related motive. They pointed to the dramatic rise in treatment programs for this population and examined psychosocial correlates of adolescent substance abusers in treatment and found that higher levels of psychological distress, lower levels of perceived low, and low self-esteem appeared to be related to substance abuse in this population, compared to adolescents not in a treatment center.

Our attention is called to the developmental trends in the contribution of evaluations by significant others (mother, father, teacher, friend) to the self-esteem of adolescents in a study by
Lackovic-Grgin and Dekovic (1990). They found that the contribution of significant others became less important depending on the age and sex of the adolescent. Kilty (1988) in a study of drinking styles of adolescents and young adults raises our awareness about the need to focus on adolescent and young adult drinking as a complex phenomenon, where an adequate typology of drinking - both "normal" and "problem" - can be developed only by looking at the relationships among many and varied situations in which drinking may take place.

Currently little is known about patterns and trends of assessment practices in the adolescent chemical dependency field. Winters (1990) identified five sources of strain on the assessment process: (1) gaps in scientific knowledge; (2) expanding need for intervention and treatment services; (3) increased popularity of the "chemical dependency" label; (4) concerns by watchdog groups; (5) developmental issues. The lack of adequate assessment tools, create a difficult situation for the adolescent chemical dependency service provider.
In a study by Clifford (1988) the problem addressed was a comparison of families with hospitalized substance abusing adolescents to families with hospitalized non-abusing adolescents and non-dysfunctional families on cohesion, adaptability, communication, and self-esteem. The results showed that the inpatient groups were very similar in the perceptions of adolescents and their parents concerning cohesion, adaptability, open communication, problems of communication and self-esteem. To reiterate, this research was designed to investigate two issues: (1) peer relations and (2) self-esteem. Research by Johnson (1980) suggests that peers can have a significant impact on an adolescent's behavior values and attitudes.

Having friends who use drugs, having favorable attitudes toward drug use and early first use of drugs all are associated with drug abuse among adolescents. Hawkins et al. (1985), and Braucht et al. (1973), demonstrated that high use of alcohol among college students was found to be associated with high alcohol use among parents. A family history of alcoholism, criminality, family
disorganization, parental drug use, and divorce are all associated with chemical use (Hawkins, et al., 1985). Adolescent at risk for chemical abuse and chemical dependency constitute a highly diversified group in terms of age background, level of psychopathology, life adjustment, and coping skills, O’Connell, (1989). The influence of home and peers may exert a greater impact on the adolescent’s self-esteem than the school environment. However, schools can provide an environment that nurtures students and serves as a "buffer" when they are confronted with home or peer situations that threaten self-esteem.

According to Laing and Bruess (1989), self-esteem grows and flourishes in a positive atmosphere and a safe environment. They feel self-esteem grows when adults with high self-esteem to promote self-esteem in the children they teach and nurture. A self-esteem promoting school environment should nurture mutual respect, value and uniqueness, personal power and responsibility, and positive goals.
THEORETICAL ORIENTATIONS

Any number of theoretical orientations could be used to inform this research. The researcher will use (1) Ecological Perspective and (2) Erikson Psychosocial Developmental Perspective. According to McRoy (1990) the underlying theories of these two approaches postulate that a dynamic interdependence exists between resources, people and varying informal and formal systems.

Ecological and Psychosocial Developmental theories can be expanded to include an understanding of large systems, can in an integrated fashion help to address the critical relationship between post history and current problems and between micro and macro issues. The researcher advocates the combined theoretical approaches of (German and Gitterman, 1980; Erickson 1959). The combined theoretical approach offers a more effective way of assessing specific micro-macro issues increased opportunities for identification and internalization systems that adversely impacts this population of teenage substance abuser.
Bronfenbrenner (1977), notes that the ecological perspective is useful in viewing the growing child and adolescent as an active agent in series of interlocking systems, ranging from the microsystems of the family and the schools, to the macro system of governmental social and economic policies. The ecological perspective is relevant in analyzing the impact of poverty, discrimination, and social isolation on the psychosocial development and adjustment of children and youth.

Erikson (1959) notes that the developmental perspective provides a framework for examining the influence of race and ethnicity on the psychosocial tasks of growing up in this country. He proposes that there are few psychosocial stages from birth to late adolescence, each posing a specific developmental challenge on the growing child to master. The outcome of each stage is determined by an interaction of the individual's personality attributes, relationships with significant others, and opportunities available in the environment.
Definition of Terms

Peer Group - A differentiated cluster of identifiable types or crowds who differ drastically in their orientation toward conventional, moral, social parental, religious, school, sport, dating, drug and other values (Clark-Stewart et al. 1988).

Peer Pressure - A repressive force one experiences and acts without examining the consequences regardless of relevant differences in the value orientation (Baker 1987).

Self-esteem - Can be viewed as a positive attitude towards oneself and behavior. Often this personal disposition is lasting, however, the self-evaluation may shift depending on the environment (Baker 1987).

Self-concept - An individual's appraisal or evaluation of himself.

Adolescent - Is considered in relation to other developmental stages and in terms of the psychological dynamics involved. Looking at the role that adolescence plays is total development and in helping the individual establish identify is an example of such (Wolman, 1987).
Chemical Dependency - A disease which controls that person's life in the pursuit of intoxication. This disease has no respect for the age of an individual.

Diagnosis - The process of identifying a problem and its primary causes and formulating a solution.

Patterns - Behaviors display by a person that's carried out in a specific style.

Substance Abuse - A disorder related to the unhealthy use of alcohol or drugs (Barker, 1987).

Hospitalized - When an individual is placed as a patient in a hospital or treatment center.

Non-Hospitalized - Individual not placed in a hospital or treatment center.

Statement of the Hypotheses

1. There is no significant difference in the self-esteem of hospitalized substance abusing teenagers and non-hospitalized teenagers.

2. There is no significant difference in peer pressure among hospitalized substance abusing teenagers and non-hospitalized teenagers.
CHAPTER THREE

METHODOLOGY

Research Design

This is an exploratory descriptive study. This exploratory descriptive study will focus on collected data relevant to the subject of research. This type of study will permit this researcher to draw from concepts used in social and behavioral sciences, such as peer pressure and self-concept. It will permit this researcher to draw from detailed information about the interrelationship of certain variables concerning the phenomenon in question. It is intended in this study to explore the major factors that contribute to the differential patterns of substance abuse among hospitalized and non hospitalized adolescents.

Sampling

The non-probability convenience sample was used for this study. Non probability sampling does not provide an equal chance for inclusion to each member of the population. This sample consisted of the individuals who were convenient to the researcher and willing to respond to the researcher's questionnaire.
The sampling population was drawn from the in-patient (hospitalized) substance abusing adolescents in treatment at Laurel Heights Hospital in Atlanta, Ga., and non-hospitalized teenagers from Kelly Chapel United Methodist Church's youth department in Decatur, Ga.

Variables used to select this population included confirmed substance abuse among adolescents between the ages of thirteen (13) through seventeen (17). A total of forty-five (45) teenagers, hospitalized and non-hospitalized, were initially interviewed and met the criteria; however, only twenty (20) agreed to participate in the sample group.

Of the 10 females and 10 males, all subjects were between the ages thirteen (13) through seventeen (17) experiencing varying aspects of psychosocial and ecological factors related to adolescent drug use.

**Data Collection Procedure (Instrumentation)**

Social work research draws upon a wide range of information and observation. Much of the material used in the process of conducting this study was drawn from Fitts' Tennessee Scale of Self-Concept,

Data Analysis

The collected data was coded and analyzed using SPSSX batched system on the VAX computer system of the Clark Atlanta University Center. Descriptive statistics, frequency-distribution, percentages, and T-Test were used to analyze the data.
CHAPTER FOUR

PRESENTATION OF THE RESULTS

This study addressed the differential patterns of substance abuse among hospitalized and non-hospitalized teenagers, measuring concepts of self-esteem and peer pressure.

The null hypotheses:

1. There is no significant difference in the self-esteem of hospitalized substance abusing teenagers and non-hospitalized teenagers.

2. There is no significant difference in the peer pressure experienced by hospitalized substance abusing teenagers and non-hospitalized teenagers.

Using the Fitts Tennessee Self Concept Scale, and Johnston's et al. Nations High School Seniors Questionnaire on Peer Pressure, together with frequency distribution, percentages, and T-Test, the results of which supported the null hypotheses that: there is no statistically significant difference in the self-esteem and peer pressure of hospitalized
substance abusing teenagers and non-hospitalized teenagers.

**Descriptive Results**

Table #1 Frequency Distribution of Demographic Data

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<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Baptist</td>
<td>5</td>
<td>25.0</td>
</tr>
<tr>
<td>Methodist</td>
<td>8</td>
<td>40.0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Ethnic:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>11</td>
<td>55.0</td>
</tr>
<tr>
<td>White</td>
<td>9</td>
<td>45.0</td>
</tr>
</tbody>
</table>

The cumulative data of the demographic variables showed that the questionnaire was completed by 10 males (50%) and 10 (50%) females. Eleven (55%) of the participants were Black, and nine (45%) were White. Thirteen (65%) participants resided with both parents, six (30%) with their mother and one (5%) other. The sample was representative of all age groups and grade levels. The majority of the sample participants were ages 15 (40%) and 13 (25%) with most being in the 8th grade. The sample’s religious preference was primarily of Methodist (40%), Baptist (25%).
Question: On how many occasions have you had alcohol, marijuana, cocaine, heroin, inhalants, in your lifetime, last month, during last thirty days?

Table #2 Frequency Distribution of Substance Usage

<table>
<thead>
<tr>
<th>Variable</th>
<th>Occasions</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Life</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>time</td>
<td>Mos days</td>
<td>time</td>
</tr>
<tr>
<td>Alcohol</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>3-5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>6-9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>10-19</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>20-39</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>40+</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Marijuana</td>
<td>0</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3-5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6-9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>10-19</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>20-39</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>40+</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>More than two times</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Crack</td>
<td>0</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>More than two times</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Heroin</td>
<td>0</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>More than two times</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Table #2 Frequency Distribution of Substance Usage

<table>
<thead>
<tr>
<th>Variable</th>
<th>Occasions</th>
<th>Frequency</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhalants</td>
<td>0</td>
<td>10 15 19  5.0</td>
<td>75.0 95.0</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>2 0 0 10.0</td>
<td>0 0</td>
</tr>
<tr>
<td></td>
<td>3-5</td>
<td>0 1 0 5.0</td>
<td>0 0</td>
</tr>
<tr>
<td>More than five times</td>
<td>8 4</td>
<td>0 40.0 20.0 0</td>
<td></td>
</tr>
</tbody>
</table>

In response to Question Number 2, the Frequency Distribution Table shows what substances were being used and what prevalence level abuse was occurring. The examination of the table also shows that adolescents are more likely to indulge in the consumption of alcohol and the ingestion of marijuana. It should be noted that the sample group has at least during one point in life used cocaine, crack, heroin and inhalants.

Question: The person who primarily suggested I use a substance was:

Table #3 Introduction/Substance Use

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close Friend (same sex)</td>
<td>6</td>
<td>30.0</td>
</tr>
<tr>
<td>Parent</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Acquaintances</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>25.0</td>
</tr>
</tbody>
</table>
Table 3 revealed that close friends of the same sex had the most influence on this population’s introduction to substance use or abuse. The sample group were equally influenced by parents and acquaintances. It also revealed that there are other sources that may influence drug use in this population which has not been identified by this population. Introduction to drug use is not exclusive to close friends (same sex), parents and acquaintances.

Question: The majority of the time I use a substance (if any):

Table #4 Substance Abuse/Use with or without Peers

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>With 1 or 2 others (same sex)</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>With 1 or 2 others (opposite sex)</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>With Parents</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td>With Others</td>
<td>3</td>
<td>15.0</td>
</tr>
</tbody>
</table>

Table 4 identifies this population’s abuse of substances with parents 20.0 percent of the time. The table also showed that the sample group abused substances alone and with others 15.0 percent of the
time. The abuse of substances with others same sex 5.0 percent of the time and with others opposite sex 10.0 percent.

Table #5 T-test Results of Self-Esteem/Self-Concept

<table>
<thead>
<tr>
<th>Items</th>
<th>T-value</th>
<th>Degrees of Freedom</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am a decent sort of person.</td>
<td>1.50</td>
<td>18</td>
<td>.151</td>
</tr>
<tr>
<td>I am a bad person.</td>
<td>-.23</td>
<td>18</td>
<td>.820</td>
</tr>
<tr>
<td>I am popular with boys/girls.</td>
<td>.80</td>
<td>18</td>
<td>.431</td>
</tr>
<tr>
<td>I do not always tell the truth.</td>
<td>.43</td>
<td>18</td>
<td>.673</td>
</tr>
<tr>
<td>I am a moral failure.</td>
<td>-.78</td>
<td>18</td>
<td>.443</td>
</tr>
<tr>
<td>I have a lot of self-control.</td>
<td>.191</td>
<td>18</td>
<td>.072</td>
</tr>
<tr>
<td>I am an important person to my friends and family.</td>
<td>.70</td>
<td>18</td>
<td>.490</td>
</tr>
<tr>
<td>I am not loved by my family.</td>
<td>-.25</td>
<td>18</td>
<td>.809</td>
</tr>
<tr>
<td>I am satisfied to be just what I am.</td>
<td>3.04</td>
<td>18</td>
<td>.007</td>
</tr>
<tr>
<td>I am satisfied with my family.</td>
<td>3.24</td>
<td>18</td>
<td>.005</td>
</tr>
<tr>
<td>I am no good at all from a social standpoint.</td>
<td>.42</td>
<td>18</td>
<td>.676</td>
</tr>
<tr>
<td>I wish I could be more trustworthy.</td>
<td>-1.67</td>
<td>18</td>
<td>.112</td>
</tr>
<tr>
<td>I shouldn’t tell so many lies.</td>
<td>-2.20</td>
<td>18</td>
<td>.041</td>
</tr>
<tr>
<td>I am too sensitive to things my family says.</td>
<td>.90</td>
<td>18</td>
<td>.380</td>
</tr>
<tr>
<td>I should love my family more.</td>
<td>.00</td>
<td>18</td>
<td>1.000</td>
</tr>
<tr>
<td>I try to change when I know I’m doing things that are wrong.</td>
<td>.20</td>
<td>18</td>
<td>.841</td>
</tr>
<tr>
<td>I try to play fair with my friends and family.</td>
<td>.46</td>
<td>18</td>
<td>.651</td>
</tr>
<tr>
<td>I do what is right most of the time.</td>
<td>.86</td>
<td>18</td>
<td>.400</td>
</tr>
<tr>
<td>I solve my problems quite easily.</td>
<td>.94</td>
<td>18</td>
<td>.358</td>
</tr>
<tr>
<td>I quarrel with my family.</td>
<td>-1.41</td>
<td>18</td>
<td>.176</td>
</tr>
</tbody>
</table>
The t-test analysis was used to test the two groups and all the items measuring the self-esteem. Generally the overall result of the t-test analysis did not show a significant difference between the two groups, however, hospitalized teenagers chose items such as "I am satisfied to be just what I am" (level of significance .007), "I am satisfied with my family" (level of significance .005), which did show a significant difference.
CHAPTER FIVE

SUMMARY AND CONCLUSION

The results of this study supported the null hypothesis. Based on the overall analysis of the t-test, it was determined that there is no significant difference between the two groups self-esteem, because the sample size was too small and the hospitalized adolescents may have not shown a significant difference in self-esteem because of being in treatment. This is further supported by (Clifford 1988), in a study that revealed adolescents hospitalized and not hospitalized were quite similar in the perceptions of self-esteem. In addition, from the descriptive analysis of the study, peer influence may be accountable to drug and alcohol use. This too is supported by (Halebsky 1987), regarding the results of a study showing a correlation does exist between parent and peer drug usage, which increases adolescent substance abusers.

According to the researcher's findings, 20 percent of this population used drugs with parents and 30 percent used drugs with others or alone.
Furthermore, 30 percent of the population was introduced to substance by close friends (same sex); 25 percent was others and 30 percent was parents and acquaintances.

Social workers in the field working with the substance abusing adolescent population will require improved assessment practices. It is encouraging that professionals attempt to use a more standardized criteria and methods of adolescent assessment. The tasks associated with identifying problems, selecting the appropriate referral, and assigning the adolescent to the proper treatment regimen require, tools of a different nature than the tools presently available.

The researcher views the ecological and developmental perspectives as a means of understanding the larger systems, which can assist professionals in addressing the critical relationship between post history and current problems and between micro and macro factors.
Limitation of the Study

The major limitation of this study was due to the small sample size. The results of this study may not be generalized to the larger population.

Suggested Research Directions

Suggested research directions reflect the thinking of Winters (1990), that there is a need for current assessment practices and tools. The need exists due to a lack of well established, standardized assessment tools and because of expanding demands and strains on the chemical dependency service delivery system to the adolescent. This include the requirement of filling the knowledge gaps, expanding needs for services, elevating the "chemical dependency" label, making sure referrals are appropriate and being familiar with developmental issues.

With improved assessment instrumentation, many of the issues mentioned above should be addressed and more valid detection of adolescents' needs and the type of referral. Well developed clinical instruments can provide a data base from which
researchers can more systematically close important knowledge gaps (Winters 1990).
CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICES

The circumstances of substance abuse and implications for practice will be discussed. Substance abuse theory, school and peer environment, and family are examined in relations to prevention and treatment. The unpretentious nature of substance abuse must be identified and what variables that enacts the biological, cognitive, and learning roles that maybe significant in the development and maintenance of substance abuse behaviors need to be ascertained.

Because adolescence is a critical point in developing socially, cognitively and academically, it is essential that social workers identify appropriate interventions to decrease substance abuse during this point. School and peer group early interventions can negate the powerful influence of peers. Programs must take advantage of peer pressure in a positive way. Following the social work practice code of ethics by being non-judgmental and developing
self-esteem in this vulnerable population are goals of utmost urgency. These programs consist of interventions such as; teams-games tournaments, biological, psychological, and sociocultural determinants of drug abuse education classes, and assisting adolescents in learning basic knowledge about drug consumption and usage.

Moreover, the older family member needs to be a positive role model. In the home, adolescents can find discipline and guidance from loved ones who care about them. Thenceforth, the home is the stabilizing influencing factor for youth. Family group intervention would be advantageous to the substance abusing adolescent. With participation of significant family members, problematic avenues within the family may be addressed.

Further, the ecological perspective and the developmental perspective are useful in viewing the growing child and adolescent as an active part in numerous interlocking systems and examining the influence of race and ethnicity on the psychosocial tasks of growing up. When specifically looking at the ecological perspective, the social worker must
analyze the impact of poverty, discrimination, and social isolation on the psychosocial development and adjustment of children and adolescents. Developmentally, the clinician must recall the five psychosocial stages of development, from birth to late adolescence becoming aware that each stage possesses a specific developmental challenge.

The solution to the problem of substance abuse requires an all-out effort by societal forces that are capable of effecting change (Wodarski 1990). Families, schools and peers all possess the power to eliminate this social dilemma.


Clifford, M. W. (1988). A comparison of families with hospitalized substance abusing adolescents to families with hospitalized non-abusing adolescents and non dysfunctional families on cohesion, adaptability, communication and self-esteem. Tulane University, DSW Dissertation,


*Adolescence, 22*(88), 962-967.

*American Journal of Drug and Alcohol Abuse, 3*, 529-543.


Health and Human Services Publications.


APPENDICES
March 19, 1991

Dear Participant:

My name is Deborah Sills. I am a graduate student at Clark Atlanta University. I am conducting a research study designed to assess the psychosocial and peer influences on substance misuse among male and female adolescents hospitalized and non hospitalized. This should take you at least 30 minutes. Your participation is strictly VOLUNTARY.

DO NOT place your name on the questionnaire. Your answers will be completely anonymous. I would like for you to answer each question as carefully and accurately as possible.

Thank you for your cooperation.

Sincerely,

Deborah E. Sills
Clark Atlanta University

Hattie Mitchell
Thesis Instructor

Attachment
Lawrence D. Baker, M.D.
Medical Director
Laurel Heights Hospital
934 Briar Cliff Road, N.E.
Atlanta, GA 30306

Dear Dr. Baker:

My names is Deborah Sills and I’m a graduate student from Clark Atlanta University. I am currently an MSW Intern here at Laurel Heights Hospital. I’m requesting to use your facility in assisting me in completing my thesis. My thesis statement is "The Differential Patterns of Substance Abuse Among Adolescents Hospitalized and Non-Hospitalized".

I would like to distribute approximately twenty (20) questionnaires that will consist of 20 to 30 questions among the population of adolescents who’ve misused substances. Confidentiality will be ensured by not requiring the patients to put their names on the questionnaire. Upon completing the data analysis, a copy of the results will be given to the facility. This questionnaire is a part of my methodology and will help me complete my research project. Your granting me this privilege will be greatly appreciated.

Sincerely,

Deborah E. Sills
Clark Atlanta University

Hattie Mitchell,
Thesis Advisor
PART I

INSTRUCTIONS

1. This is not a test, so there are no right or wrong answers; we would like you to work fairly quickly, so that you can finish. Your responses are confidential.

2. All of the questions should be answered by marking one of the answer spaces. If you don’t always find an answer that fits exactly, use the one that comes closer.

3. Please mark a distinct X on the line just before the answer you prefer. Please follow the instructions carefully.

What sex are you? (Mark an X on one line only)

   Male       Female

How old are you? (Mark an X on one line only)

   13
   14
   15
   16
   17

What grade are you in now? (Mark an X on one line only)

   7th grade       10th grade (sophomore)
   8th grade       11th grade (junior)
   9th grade (freshman) 12th grade (senior)

Adults in the home. (Mark an X on one line only)

   mother       both
   father       other
What is your religious background? (Mark an X on one line only)

- Catholic
- Baptist
- Muslim
- Methodist
- Jehovah Witness
- Pentecostal
- Presbyterian
- Other

(Please identify)

1. Have you ever had any beer, wine, or liquor to drink?

- No --- GO TO QUESTION 6
- Yes

2. On how many occasions have you had alcoholic beverages to drink...(mark one X for each question)

   a. in your lifetime?

      - 0 occasions
      - 1-2 occasions
      - 3-5 occasions
      - 6-9 occasions
      - 10-19 occasions
      - 20-39 occasions
      - 40 or more

   b. during the last 12 months?

      - 0 occasions
      - 1-2 occasions
      - 3-5 occasions
      - 6-9 occasions
      - 10-19 occasions
      - 20-39 occasions
      - 40 or more

   c. during the last 30 days?

      - 0 occasions
      - 1-2 occasions
      - 3-5 occasions
3. On how many occasions (if any) have you used marijuana (grass, pot) or hashish (has, hash oil)...(mark one X for each question)

   a. in your lifetime?
      - 0 occasions
      - 1-2 occasions
      - 3-5 occasions
      - 6-9 occasions
      - 10-19 occasions
      - 20-39 occasions
      - 40 or more

   b. during the last 12 months?
      - 0 occasions
      - 1-2 occasions
      - 3-5 occasions
      - 6-9 occasions
      - 10-19 occasions
      - 20-39 occasions
      - 40 or more

   c. during the last 30 days?
      - 0 occasions
      - 1-2 occasions
      - 3-5 occasions
      - 6-9 occasions
      - 10-19 occasions
      - 20-39 occasions
      - 40 or more

4. On how many occasions (if any) have you used cocaine (sometimes called "coke")...(mark one X for each question)

   a. in your lifetime?
      - 0 occasions
      - 1-2 occasions
      - 3-5 occasions
      - 6-9 occasions
      - 10-19 occasions
      - 20-39 occasions
      - 40 or more
6. On how many occasions (if any) have you used heroin (smack, horse, skag) ...(mark one X for each question)

a. in your lifetime?
0 occasions
1-2 occasions
3-5 occasions
6-9 occasions
10-19 occasions
20-39 occasions
40 or more

b. during the last 12 months?
0 occasions
1-2 occasions
3-5 occasions
6-9 occasions
10-19 occasions
20-39 occasions
40 or more

c. during the last 30 days?
0 occasions
1-2 occasions
3-5 occasions
6-9 occasions
10-19 occasions
20-39 occasions
40 or more
7. On how many occasions (if any) have you sniffed glue or breathed the contents of aerosol spray cans, or inhaled any other gases or sprays in order to get high...(mark one X for each question)
   a. in your lifetime?  
      ____ 0 occasions  
      ____ 1-2 occasions  
      ____ 3-5 occasions  
      ____ 6-9 occasions  
      ____ 10-19 occasions  
      ____ 20-39 occasions  
      ____ 40 or more  
   b. during the last 12 months?  
      ____ 0 occasions  
      ____ 1-2 occasions  
      ____ 3-5 occasions  
      ____ 6-9 occasions  
      ____ 10-19 occasions  
      ____ 20-39 occasions  
      ____ 40 or more  
   c. during the last 30 days?  
      ____ 0 occasions  
      ____ 1-2 occasions  
      ____ 3-5 occasions  
      ____ 6-9 occasions  
      ____ 10-19 occasions  
      ____ 20-39 occasions  
      ____ 40 or more  

8. When (if ever) did you first do each of the following things?
   a. try an alcoholic beverage more than just a few sips...  
      ____ never  
      ____ 6 or below  
      ____ grade 7 or 8  
      ____ grade 9  
      ____ grade 10  
      ____ grade 11  
      ____ grade 12
b. try marijuana

<table>
<thead>
<tr>
<th>Grade</th>
<th>Never</th>
<th>6 or below</th>
<th>Grade 7 or 8</th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Grade 11</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

c. try cocaine

<table>
<thead>
<tr>
<th>Grade</th>
<th>Never</th>
<th>6 or below</th>
<th>Grade 7 or 8</th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Grade 11</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
d. try crack

<table>
<thead>
<tr>
<th>Grade</th>
<th>Never</th>
<th>6 or below</th>
<th>Grade 7 or 8</th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Grade 11</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
e. try heroin

<table>
<thead>
<tr>
<th>Grade</th>
<th>Never</th>
<th>6 or below</th>
<th>Grade 7 or 8</th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Grade 11</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
f. try inhalants

<table>
<thead>
<tr>
<th>Grade</th>
<th>Never</th>
<th>6 or below</th>
<th>Grade 7 or 8</th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Grade 11</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. The person who primarily suggested I used a substance was: (mark an X on one line only)

<table>
<thead>
<tr>
<th>Close friend (same sex)</th>
<th>Brother or sister</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10. The majority of the time I use a substance (if any) (mark an X on one line only)

___ alone
___ with 1 or 2 others (same sex)
___ with 1 or 2 others (opposite sex)
___ with parents
___ with others

11. When would you most likely...(mark one X for each question)

a. drink alcohol, (beer, wine, liquor)
   ___ never
   ___ usually when I'm alone
   ___ usually when I'm with close friends
   ___ usually with others

b. use marijuana (pot, grass)
   ___ never
   ___ usually when I'm alone
   ___ usually when I'm with close friends
   ___ usually with others

c. use cocaine (coke)
   ___ never
   ___ usually when I'm alone
   ___ usually when I'm with close friends
   ___ usually with others

d. use crack (rock)
   ___ never
   ___ usually when I'm alone
   ___ usually when I'm with close friends
   ___ usually with others
e. use heroin  
   — never  
   — usually when I'm alone  
   — usually when I'm with close friends  
   — usually with others  

f. use inhalants (sniff glue, gases, or aerosol spray)?  
   — never  
   — usually when I'm alone  
   — usually when I'm with close friends  
   — usually with others  

12. If you were at a party and a friend offered to share alcohol with you, would you  

   — accept the offer  
   — say no thanks  
   — other  

b. marijuana  
   — accept the offer  
   — say no thanks  
   — other  

c. cocaine  
   — accept the offer  
   — say no thanks  
   — other  

d. crack  
   — accept the offer  
   — say no thanks  
   — other  

e. heroin  
   — accept the offer  
   — say no thanks  
   — other  

f. inhalants  
   — accept the offer  
   — say no thanks  
   — other
13. How many of your friends would you estimate:

a. smoke marijuana
   - none
   - a few
   - some
   - most
   - all

b. take cocaine
   - none
   - a few
   - some
   - most
   - all

c. smoke crack
   - none
   - a few
   - some
   - most
   - all

d. try heroin
   - none
   - a few
   - some
   - most
   - all

e. try inhalants
   - none
   - a few
   - some
   - most
   - all

f. drink alcoholic beverages
   - none
   - a few
   - some
   - most
   - all

g. get drunk at least once a week
   - none
   - a few
   - some
   - most
   - all
14. How do you think your CLOSE FRIENDS feel (or would feel) about YOU doing each of the following things?

a. trying marijuana (pot, grass) once or twice
   - not disapprove
   - disapprove
   - strongly disapprove

b. smoking marijuana occasionally
   - not disapprove
   - disapprove
   - strongly disapprove

c. smoking marijuana regularly
   - not disapprove
   - disapprove
   - strongly disapprove

d. trying cocaine once or twice
   - not disapprove
   - disapprove
   - strongly disapprove

e. trying crack once or twice
   - not disapprove
   - disapprove
   - strongly disapprove

f. taking one or two drinks nearly everyday
   - not disapprove
   - disapprove
   - strongly disapprove

g. taking four or five drinks nearly everyday
   - not disapprove
   - disapprove
   - strongly disapprove

h. having five or more drinks once or
twice each weekend  

15. During the last 12 MONTHS, how often have you been around people who were taking each of the following to get high or for "kicks"?

a. marijuana (pot, grass) or hashish  
b. crack (rock)  
c. cocaine (coke)  
d. heroin (smack, horse)  
e. alcoholic drinks (beer, wine, liquor)  

16. Reasons for using drugs (choose one only)

17. Reasons for using drugs (choose one only)
you have a doctor’s prescription (for
allergies, nerves, etc.)
for curiosity — want to find out what it’s
like

18. Reasons for using drugs (choose one only)

with drugs it’s easier to express your
feelings

drugs are a good way to change your mood

drugs are one way to rebel against adult
authority

to be more creative — writing, music,
thinking

19. On one or more occasions, I have taken drugs,
mostly because people would have put me down if
I hadn’t.

true false

20. I don’t believe much in planning for the future,
life right now is the most important thing.

true false

PART II

INSTRUCTIONS

The statements below are to help you describe
yourself as you see yourself. Please respond to them
as if you were describing yourself to yourself. You
are to answer every item? Read each statement
carefully; then select one of the five responses
listed below. You are to put a circle around the
response you choose. If you want to change an answer
after you have circled it, do not erase it but put an
X mark through the response and then circle the
response you want.

Completely false
Mostly Partly false Mostly true Completely true
1 2 3 4 5
1. I am a decent sort of person 1 2 3 4 5
2. I am a bad person 1 2 3 4 5
3. I am popular with boys/girls 1 2 3 4 5
4. I do not always tell the truth 1 2 3 4 5
5. I am a moral failure 1 2 3 4 5
6. I have a lot of self control 1 2 3 4 5
7. I am an important person to my friends and family 1 2 3 4 5
8. I am not loved by my family 1 2 3 4 5
9. I am satisfied to be just what I am 1 2 3 4 5
10. I am satisfied with my family 1 2 3 4 5
11. I am no good at all from a social standpoint 1 2 3 4 5
12. I wish I could be more trustworthy 1 2 3 4 5
13. I shouldn’t tell so many lies 1 2 3 4 5
14. I am too sensitive to things my family says 1 2 3 4 5
15. I should love my family more 1 2 3 4 5
16. I try to change when I know I’m doing things that are wrong 1 2 3 4 5
17. I try to play fair with my friends and family 1 2 3 4 5
18. I do what is right most of the time 1 2 3 4 5
19. I solve my problems quite easily 1 2 3 4 5
20. I quarrel with my family 1 2 3 4 5