



**WHY SCARE TACTICS
IN DRUG PREVENTION
MESSAGING DON'T WORK.**



ALL DRUG PREVENTION EFFORTS MEAN WELL, BUT NOT ALL OF THEM DO WELL.

STRATEGIES BASED ON SCARE TACTICS JUST DON'T WORK.

In the early 2000s, methamphetamine use in Montana reached epidemic proportions. Communities struggling to save their young people made a desperate attempt to get their attention by launching a campaign based on scare tactics. The intensive campaign used television, radio, and billboards to graphically illustrate the worst consequences of meth use. Scenarios included meth users threatening to kill their parents, being raped, and even prostituting themselves to fund their methamphetamine use.

Unfortunately, for all of the energy and money poured into this scare tactic campaign, it didn't deliver the expected results.¹ In fact:

- The perception of how risky meth use is actually decreased among young people in Montana.
- The percentage of teens reporting that they strongly approve of regular meth use increased four-fold.
- The percentage of teens reporting they strongly disapprove of meth use decreased with each year of the campaign.
- 40% - 50% of teens indicated that many of the ads exaggerated the risks. This percentage soared to 75% among Native American teens, a group at high-risk for meth use.

SCARE TACTICS CAN BACKFIRE, AND THEY OFTEN DO.

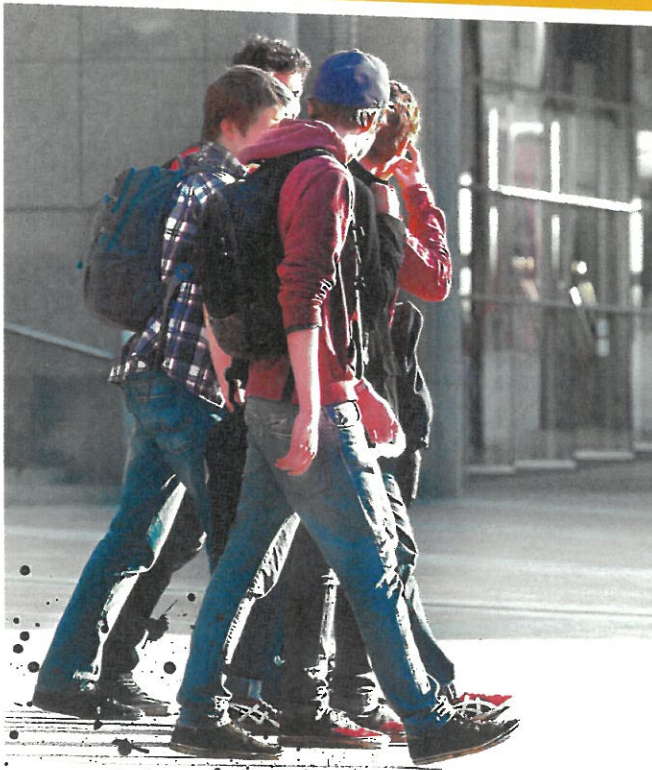
When adults are intent on protecting young people from a frightening danger, such as a new drug trend, they often attempt to instill fear as a deterrent. The goal is to emphasize the worst possible scenario in order to create fear and anxiety in our youth with the hope that fear alone will prevent risky behavior. These are called "scare tactics" and they may include the use of:

- Graphic warnings
- Graphic images
- Scary stories told by recovering addicts
- Tragic consequences told by family members or others impacted by someone else's use
- Mock DUI crashes

While intuitively this sounds like an effective approach, decades of research show that relying on fear to prevent problems like alcohol and other drug use simply does not work. Even worse, **scare tactics can actually increase problem behavior.**



WHY DON'T SCARE TACTICS WORK?



REASON #1: PEOPLE ARE HARDWIRED TO DEFEND AGAINST NEGATIVE MESSAGING.

Teens, like all human beings, have natural defenses to feelings of fear. As fear increases, defenses also increase to help control the intense emotions that are triggered. This is a normal and healthy human response.²⁻⁵

When faced with scare tactics, a teen's natural defense might be:

DENIAL — "It won't happen to me."

AVOIDANCE — "This is just too scary, I am not going to think about it."

BLUNTING/NUMBING; FAILURE TO PROCESS OR TAKE IN THE MESSAGE — "I don't understand."

COUNTERING WITH SKEPTICISM — "They're just trying to manipulate me, I'm going to ignore them." Or "I know people who do it, and they seem fine."

MAKING FUN OF THE MESSAGE — "This is your brain on drugs. This is your brain on drugs with a side of bacon."

Research shows that increasing fear about drugs and alcohol without providing clear action steps can actually increase use. This happens when we arouse too much fear and provide too simple of an action message.²⁻⁵

Action messages cannot be about what NOT to do. Youth must be taught what TO do, and have an opportunity to practice the skill or behavior. Youth need the opportunity to learn decision-making, coping, and resistance skills. Research on effective prevention shows that these skills are best taught in the context of age-appropriate, comprehensive prevention programs that include interactive, skills-based education.⁶



WHY DON'T SCARE TACTICS WORK?

REASON #2: YOUNG PEOPLE FILTER INFORMATION DIFFERENTLY THAN ADULTS.

Young people don't have the life experience to understand the permanence of decisions or consequences of risky behavior. Even if they are warned of possible dangers, there are key developmental issues that influence how they filter such messages.

Adults filter most information using logic and rational thinking. If they know one choice could have dire consequences, they make a different choice. Young people filter the same information differently because the prefrontal cortex (the area of the brain responsible for controlling impulses, exercising judgment, and decision-making) does not finish developing until the mid-twenties.⁷⁻¹⁰

We also know that young people experience hormonal flooding during puberty, which can create a "tinderbox of emotions." They become accustomed to more intense feelings and often seek out situations that create intense feelings as a result.¹¹ This is known as sensation-seeking. Teens are naturally driven to engage in risky, impulsive behavior, and without a fully developed prefrontal cortex, they don't have the ability to "put the brakes on" when needed.

This research on emotions during adolescence explains why scare tactics don't work: Teens live in the moment. They may be overcome with feelings during a prevention presentation designed to elicit strong emotions, and the presenter will assume the message has gotten through. However, teens may later be just as affected by strong emotions, such as fear of rejection or excitement, when confronted with the choice to use. Research has found that the emotions teens experience during prevention presentations do not correspond to choices made later when alcohol or drugs are available.

When youth are experiencing intense emotions, it is difficult for them to think through potential outcomes, understand the consequences of their decisions, or even use common sense.¹² Rather than employing scare tactics in an effort to get through to them, we can help prepare teens to make important decisions even during moments of intense emotion. This can be done through education that focuses on skills development, as part of a comprehensive prevention approach.



REASON #3: HIGH-RISK GROUPS CAN BE MORE ATTRACTED TO RISKY BEHAVIOR.

Brain research outlines concerns for all young people, but underlines why scare tactics seem to backfire most with high-risk youth. Some youth are wired more strongly for sensation-seeking and are more impulsive risk-takers. People with these traits need a lot of activity and stimulation or they get bored easily. This, coupled with an underdeveloped brain, can make some youth more likely to develop alcoholism and other drug problems.¹³⁻²⁷

When high-risk youth are presented with scare tactics, the warnings trigger defense mechanisms while the danger creates a thrill. Rather than serving as a warning, the messages can fuel high-risk behavior. Without full impulse control or judgment, a high-risk youth is not able to process these dire warnings and adopt preventative behaviors in the way adults hope.

Scare tactics are especially dangerous for youth who have already experimented with these substances and have favorable views of them. A study of the effectiveness of the National Youth Anti-Drug Media Campaign found that youth who already held strong anti-marijuana views were unaffected by the ads, while those youth with more pro-marijuana attitudes actually ricocheted in the wrong direction, rejecting the message and becoming more pro-marijuana.²⁸ The more favorable the prior attitude, the less the warnings will be believed.²⁹⁻³¹

A better approach would be to teach preventative behaviors by presenting positive alternatives. When prevention messages do not preach, there is nothing to rebel against. Staying positive can reduce the likelihood that the strategy will fuel further high-risk behavior.

REASON #4: STRONG WARNINGS CAN SEND UNINTENDED MESSAGES.

When adults go to extremes to get anti-drug messages through to youth, the intensity of the effort may itself be sending an unintended message. Some youth may conclude that since the adults are very concerned, drug use must be a widespread problem among their peers and that not using drugs must be difficult. In other words, youth will sense that using drugs is the norm and that their peers are not only using, but are accepting of use.

This is exactly what researchers found when they studied the effectiveness of the National Youth Anti-Drug Media Campaign with a strong focus on harms from marijuana. Over the years of the campaign, youth came to believe that their peers were using more marijuana, so they expected less social disapproval should they also use the drug.³²

Young people that already have a favorable view of drug use are invested in maintaining that view. When scare tactics underscore the belief that “everyone is doing it” their core belief is justified. The result? The message backfires, and the risky behavior is either maintained or even intensified.² The only effective way to prevent this is to offer positive, educational messages and opportunities for behavioral change.



SCARE TACTICS DON'T WORK.

Decades of research studies show that scare tactics and cautionary tales do not work. While we may see immediate emotional reactions, those temporary reactions do not warrant the risks of using scare tactics, because time and time again we reap negative results including:

- Creating messages that backfire and actually increase use, especially among our most high-risk youth
- Creating a lack of trust in other prevention messages when stories and dangers presented do not match someone's personal experiences³³⁻³⁴
- Creating the impression that drug use is happening more than it is
- Wasting precious resources of time, money, and the attention of our youth when messaging backfires or fails

LET'S FOCUS ON POSITIVE PREVENTION STRATEGIES.

Knowing that scare tactics don't work doesn't stop that first, natural instinct of "scaring them" from coming up. But, as preventionists and concerned community members, we cannot continue to repeat the mistakes of the past. Together, we must instead choose to focus on the use of effective prevention strategies.

Positive prevention provides youth with proactive steps they can take to stay healthy and drug and alcohol free. Our youth need us to help guide them through the difficulties of adolescence when emotions are high and impulse control and decision-making skills are low. We cannot add fuel to the fire by simply scaring them and then scaring them some more. Instead, we need to rely on research to help them develop the skills they need to succeed.

How can we do it? With an evidence-based, ongoing program that includes education and skill development to support decision-making, coping and resistance skills. We can start by spotlighting the many healthy, drug-free youth who are taking positive prevention actions and emphasize how and why they are able to follow-through. This approach will normalize healthy choices and increases motivation and resistance skills.

For more information on positive prevention programs, contact Prevention Action Alliance at 614.540.9985 or visit us at www.preventionactionalliance.org.

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Works Cited

1. **D., Erceg-Hurn.** Drugs, Money, and Graphic Ads: A Critical Review of the Montana Meth Project. *Prevention Science*. 2008, Vol. 9, 4, pp. 256-63.
2. *Scary warnings and rational precautions: A review of the psychology of fear appeals.* **Ruiter, R. A. C., Abraham, C., & Kok, G.** 16, 2001, *Psychology and Health*, pp. 613-630.
3. *Fear Appeals in Social Marketing: Strategic and Ethical Reasons for Concern.* **Hasting, G. & Stead, M.** 2004, *Psychology and Marketing*, Vol. 21, pp. 961-986.
4. **Findings and Theory in the Study of Fear Communications.** **Leventhal, H.** 1970, *Advances in Experimental Social Psychology*, Vol. 5, pp. 119-186.
5. *Fear Appeals and Attitude Change: Effects of a Threat's Noxiousness, Probability of Occurrence, and the Efficacy of the Coping Responses.* **Rogers, R. W., & Mewborn, C. R.** 1976, *Journal of Personality and Social Psychology*, Vol. 34, pp. 54-61.
6. *NIDA Info Facts.* U.S. Department of Health & Human Services, National Institute on Drug Abuse and the National Institutes of Health. August 2011.
7. *Brain development during childhood and adolescence: a longitudinal MRI study.* **Giedd, J.N., Blumenthal, J., Jeffries, N.O., et al.** 10, 1999, *Nature Neuroscience*, Vol. 2, pp. 861-3.
8. *The Adolescent Brain.* **Casey, B.J., Jones, R.M., & Hare, T.A.** March 2008, *Annals of The New York Academy of Sciences*, Vol. 1124, pp. 111-126.
9. **Walsh, D.** *Why do they act that way? A survival guide to the adolescent brain for you and your teen.* New York : Free Press, 2004.
10. *Structural Magnetic Resonance Imaging of the Adolescent Brain.* **Giedd, J.N.** 2004, *Annals of the New York Academy of Sciences*, Vol. 1021, pp. 77-85.
11. **Dahl, R.E.** Beyond Raging Hormones: The Tinderbox in the Teenage Brain. *Cerebrum: The Dana Forum on Brain Science*. 2003, Vol. 5, 3, pp. 7-22.
12. *Cognitive and affective development in adolescence.* **Steinberg, L.** 2, 2005, *Trends in Cognitive Sciences*, Vol. 9, pp. 69-76.
13. *Aging, alcoholism, anxiety, and sensation seeking: An exploratory investigation.* **Kilpatrick, D.G., McAlhany, D.A., McCurdy, R.L., Shaw, D.L., & Roitzsch, J.C.** 1982, *Addictive Behaviors*, Vol. 7, pp. 97-100.
14. *Childhood personality predicts alcohol abuse in young adults.* **Cloninger, C.R., Sigvardsson, S., & Bohman, M.** 1988, *Alcoholism: Clinical and Experimental Research*, Vol. 12, pp. 494-505.
15. *Application of the tridimensional personality questionnaire to a population of alcoholics and other substance abusers.* **Nixon, S.J., & Parsons, O.A.** 1990, *Alcoholism: Clinical and Experimental Research*, Vol. 14, pp. 513-517.
16. **Bates, M.E.** *Personality.* [ed.] M. Galanter. *Recent Developments in Alcoholism*. New York : Plenum Press, 1993, Vol. 11, pp. 45-61.
17. *Affectivity, family drinking history, and the development of problem drinking: A longitudinal analysis.* **Johnson, V. & Pandina, R.J.** 1993, *Journal of Applied Social Psychology*, Vol. 23, pp. 2054-2072.
18. *Social context and sensation seeking: Gender differences in college student drinking motivations.* **Beck, K.H., Thombs, D.L., Mahoney, C.A., & Finger, K.M.** 1995, *The International Journal of the Addictions*, Vol. 30, pp. 1101-1115.
19. *Sensation seeking, alcohol use and sexual risk behaviors among men receiving services at a clinic for sexually transmitted infections.* **Kalichman, S.C., Cain, D., Zweben, A., & Swain, G.** 2003, *Journal of Studies on Alcohol*, Vol. 64, pp. 564-569.
20. *Association between dopamine receptor d1 gene dde i polymorphism and sensation seeking in alcohol-dependent men.* **Limosin, F., Loze, J.Y., Rouillon, F., Ades, J., & Gorwood, S.P.** 2003, *Alcoholism: Clinical and Experimental Research*, Vol. 27, pp. 1226-1228.
21. *Personality characteristics of alcoholics as college freshmen at time of treatment.* **Kammeier, M.L., Hoffmann, H., & Loper, R.G.** 1973, *Quarterly Journal of Studies on Alcohol*, Vol. 34, pp. 390-399.
22. *Identifying future alcoholics with MMPI alcoholism scales.* **Hoffmann, H., Loper, R.G., & Kammeier, M.L.** 1974, *Quarterly Journal of Studies on Alcohol*, Vol. 35, pp. 490-498.
23. *The alcoholic personality: A re-analysis of the literature.* **Barnes, G.E.** 1979, *Journal of Studies on Alcohol*, Vol. 40, pp. 571-634.
24. **Huba, G., & Bentler, P.** Causal models of personality, peer culture characteristics, drug use and criminal behavior over a five-year span. [ed.] S. Mednick, K. Van Dusen D. Goodwin. **Longitudinal Research in Alcoholism.** Boston : Kluwer-Nihoff, 1984, pp. 73-94.
25. **Sher, K.J.** Individual-level risk factors. [book auth.] National Institute on Alcohol Abuse Research Monograph. [ed.] Zucker, Howard Boyd. *National Institute on Alcohol Abuse Research Monograph.* The Development of Alcohol Problems: Exploring the Biopsychosocial Matrix of Risk. Washington D.C. : U.S. Department of Health and Human Services, 1994, Vol. 26, pp. 77-108.
26. *Serotonin, impulsivity, and alcohol use disorders in the older adolescent: A psychobiological study.* **Soloff, P.H., Lynch, K.G., & Moss, H.B.** 2000, *Alcoholism: Clinical and Experimental Research*, Vol. 26, pp. 1609-1619.
27. *Early-onset alcoholism with conduct disorder: Go/no-go learning deficits, working memory capacity and personality.* **Finn, P.R., Mazas, C.A., Justus, A.N., & Steinmetz, J.** 2002, *Alcoholism: Clinical and Experimental Research*, Vol. 26, pp. 186-206.
28. **Hornick, R.** *Evaluation of the National Youth Anti-Drug Media Campaign: fifth semi-annual report of findings.* s.l. : Westat and Anenberg School for Communications, November 2002.
29. *Believability and attitudes toward alcohol warning label information: The role of persuasive communications theory.* **Andrews, J.C., Netemeyer, R.G., & Durvasula, S.** 1990, *Journal of Public Policy and Marketing*, Vol. 9, pp. 1-15.
30. *Effects of consumption frequency on believability and attitudes toward alcohol warning labels.* **Andrews, J.C., Netemeyer, R.G., & Durvasula, S.** 1991, *Journal of Consumer Affairs*, Vol. 25, pp. 323-338.
31. *The role of cognitive responses as mediators of alcohol warning label effects.* **Andrews, J.C., Netemeyer, R.G., & Durvasula, S.** 1993, *Journal of Public Policy and Marketing*, Vol. 12, pp. 57-68.
32. *Boomerang Ads.* *Drug and Alcohol Findings.* 2005, 14.
33. **Gordon, N., & Macalister, A.** *Adolescent Drinking: Issues and Research.* [book auth.] A.C. Petersen, C. Perry T.J. Coates. *Promoting Adolescent Health: A Dialogue on Research and Practice.* New York : Academic Press, 1982, pp. 201-233.
34. **Swisher, J.D., & Hoffman, A.** *Information: The Irrelevant Variable in Drug Education.* [ed.] Brown. *Drug Abuse Prevention: Perspectives and Approaches for Educators.* 1975.

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