Making friends and influencing people: taking the first steps towards understanding risky drinking with a deprived community

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The consequences of excessive drinking do not rebound solely on the drinker. Alcohol is often a contributory factor in violent behaviour (Room & Rossow, 2001), aggression (Bushman, 2002) and even suicide. Other social factors linked to alcohol are reduced performance at work, absenteeism (Mangione et al., 1999) and crimes like domestic violence (Kyriacou et al., 1999). Thus, alcohol-related problems contribute to social and health inequality (DoH, 2009) and reducing higher-risk drinking is a significant policy concern.

This paper shows that traditional qualitative techniques that may be adopted by social marketers in the quest to understand risky drinking may exclude those most at risk of this behaviour and its consequences. Instead, participatory techniques that prioritise informal relationships in community settings can build a clearer picture of the complex range of issues and allow marginalised voices to be heard. In the context of an uncertain future for Public Health and increasing cuts, participatory techniques may also lay a stronger foundation for devolving successful interventions and services to be sustained by the community itself.

Community Based Participatory Research, with its orientation towards “public health as social justice” (Minkler, 2004:684) is being adapted to our rather more specific goal of alcohol harm reduction interventions. For the last four months, one of the authors has spent several days and evenings each week in the communities talking to community leaders and attending local events. Building close relationships with a local councillor, youth workers, the Children’s Centre, Housing Officers, the Police, churches and local third sector organisations has given valuable insight into the issues and, vitally, introductions to local people through a trusted intermediary.

We began co-creating the research design via ‘methods stations’, which encouraged people to experiment with different ways of expressing themselves about risky drinking in context, such as visual methods (Banks, 2001), playing simple games (Choukeir, 2011) and more traditional qualitative techniques like semi-structured interviews.

People were willing to verbalise their (personal and in some cases harrowing) stories with us in these informal situations. However we found that literacy problems were common, with the result that many people felt anxious about engaging with any method that required them to read or write, particularly if doing so would expose spelling mistakes or misunderstandings publically.

Conversely, we discovered that once people had overcome their initial ‘stage fright’ at being asked to create something visual, they found the collage method enjoyable and thought this would work well for their community. We observed that this method had two advantages: it gave people something to do whilst they spoke thus avoiding direct eye contact and it inspired new directions in the conversation.

Many people we spoke to were concerned that they would ‘lose control’ of their stories. Several asked who would be told about revelations made; there seemed to be a distrust of authority and outsiders and whilst we had mitigated this somewhat by spending so much time in the community, the capital we had created didn’t extend beyond the researcher.
For these reasons, the traditional formative qualitative approach of depth interviews or focus groups is likely to unsuccessful in uncovering the range of issues in this community because only the confident, literate people with nothing to ‘hide’ or no difficult stories would come forward. In some cases we found that the informality of the ad hoc discussions in public, familiar surroundings gave people a feeling of security that would disappear in the unfamiliar, private and formal setting of traditional health research.

Emerging themes suggest that frequent moderate drinking is considered normal but that a stressful event (being a victim of crime, homelessness or even having a child) can trigger increasing use of alcohol as a coping mechanism (see also Dawson et al., 2005; Sherry et al., 2000). Apathy and mood related disorders seem common as well, with many drinkers reluctant to access services where they exist or even to engage in the community, despite the minority of people who did access services telling us that they were of very high quality and relevant to their needs. It is likely that interventions, if they are to stand a chance of success, will need to interact with risky drinkers face-to-face through people they know and trust in places they visit frequently and where they feel secure; bridging the gap between these marginalised individuals and the services that are already there to help them.

References


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