

Diamond Dialogue: A Tool to Explore Alcohol-related Harm and Strengthen Community Action

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ABSTRACT

The Diamond Dialogue has previously been used as a research tool, as a way of evaluating the effectiveness of development of interventions in changing quality of life in a variety of contexts. This paper aims to describe the development of the Diamond Dialogue as a community intervention tool to reduce alcohol-related harm. This was part of an action research study. Focus groups, using the Diamond Dialogue, were conducted during workshops to reduce alcohol-related harm in two different villages. The Diamond Dialogue was initially used as a tool to better understand how drinking was affecting their quality of life. The Diamond Dialogue was intentionally used as part of the intervention in one village, with the discussion on alcohol and quality of life leading into discussion on community level change to reduce alcohol-related harm. The discussion notes were analysed for themes related to quality of life and alcohol use. Alcohol was seen by community members to have both positive and negative effects on the community. Using the Diamond Dialogue as an intervention lead to greater levels of engagement, created a collective motivation to change and led to community level action planning. Exploring community ambivalence towards alcohol, acceptance of both the positive and negative effects and validation of the community's views provided a platform for engagement. This then led to "change talk" about adopting low-risk drinking and ownership of possible solutions for alcohol related problems.

Keywords: community intervention, alcohol harm, Diamond Dialogue, alcohol harm reduction, empowering community, community level change

INTRODUCTION

Alcohol is one of the largest contributors to the burden of disease in the world, which results in around 2.5 million deaths each year; more than HIV, malaria, or death due to warfare. Malaysia is a Muslim country and has a relatively low per capita intake of alcohol at approximately 0.82 litre per capita¹. This figure disguises the risky drinking practices among some subgroups, such as the ethnic Indians, Chinese and some of the ethnic groups in East Malaysia². East Malaysia is geographically separated from the rest of Malaysia, on the island of Borneo and consists of two states: Sabah and Sarawak. They are culturally distinct from the rest of the Malaysian population and have large Christian populations. Alcohol is considered to be part of the culture of many of the ethnic groups in Sabah³. Barlocco described how alcohol acts as an identity marker for the Kadazan (one of the largest ethnic groups); "In the case of the Kadazan (and some other Kadazan-Dusun), alcohol consumption embodies the sense of being Kadazan"⁴. Discussing alcohol-related harm with a community where alcohol has become part of the cultural identity needs to be done with great sensitivity⁵.

The Intervention Group for Alcohol Abuse was formed in 2009, with the broad aim of reducing alcohol-related harm in Sabah⁶. The members of the group were from diverse backgrounds, including clinicians, academics, Church leaders and individuals with a history of alcohol-related problems. The group trained

community leaders in recognising and helping people with alcohol-related problems and encouraging the formation of village level committees to address and minimize alcohol-related problems. This was largely successful, in that 16 out of 18 village committees formed ran a programme to reduce alcohol-related harm. These programmes included talks, workshops, alcohol-free activities and alcohol-related bylaws. Some of the village committees asked the project team to return to their communities to assist in running alcohol-related workshops. Two of these workshops were part of a small mixed-methods study to measure the effectiveness of the intervention programme and design better communication strategies. In previous community level workshops, we had used the format which is commonly used in Malaysian health promotion and included health talks, health screening and a lucky draw to encourage participation. Attempts to encourage active engagement initially had limited success, so we modified the format for this project, to specifically include more participatory elements.

The Diamond Dialogue was created as a research tool to measure the effectiveness of community level interventions on well-being⁷. This tool was initially used in this study as a way of evaluating the success of our alcohol intervention amongst communities with some participants with limited literacy and numeracy skills. While being used in this way, it was noted that the tool itself could provide an avenue for change. It has never previously been used specifically as an intervention in itself. This paper describes how the Diamond Dialogue was developed for use as an intervention tool to reduce alcohol-related harm at community level.

MATERIALS AND METHODS

This was part of an action research study, which had one of its aims to design and pilot test effective communication strategies with the community. In that process, the research method became an active part of the intervention. We

trained research assistants from the villages in action research techniques. Two workshops were held in rural villages in October and November, 2014, with the aim of reducing alcohol-related harm. Members of both villages had previously attended our community leader training workshop and had requested help from the main committee in running the workshop. The community members who had attended the initial training workshop had felt that alcohol was part of the life of the village, but also caused harm.

In both workshops talks and small group discussions were held, which aimed to create community level plans to reduce alcohol-related harm. The first workshop started with talks, followed by discussion. The second workshop started with discussion. In both workshops, the Diamond Dialogue technique was used. In the first workshop, this was done near the end of the workshop, and the purpose was only to collect baseline data for the intervention study. In the second workshop, this was done near the beginning and was used as an integral part of the small group discussion to create community level plans to reduce harm. The groups were divided by gender, with approximately 10 per group. The female groups were led by female facilitators and one of the men's groups was led by a female facilitator and one by a male facilitator. A large paper with a diamond was given to the participants (Figure 1 and Figure 2). Participants were asked four different questions: "What does happiness mean to you?", "What does unhappiness mean to you?", "What makes you happy?", "What makes you unhappy?". They were given the instruction: "Between the extremes of 'Very happy' and 'Very unhappy', where do you place your current level of happiness?" In the second workshop, participants were then led into a discussion on the role alcohol played in this and how the happiness level of the community could be increased. This then led into discussion about community level plans to reduce alcohol-related harm. In the first workshop, the discussion about community level plans had preceded the

Diamond Dialogue, so the Diamond Dialogue had not been used to help create the plans.

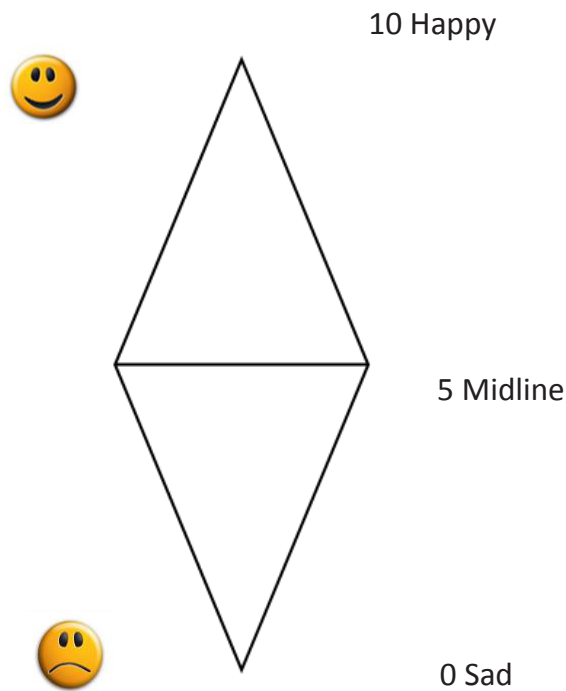


Figure 1 Diamond with categories

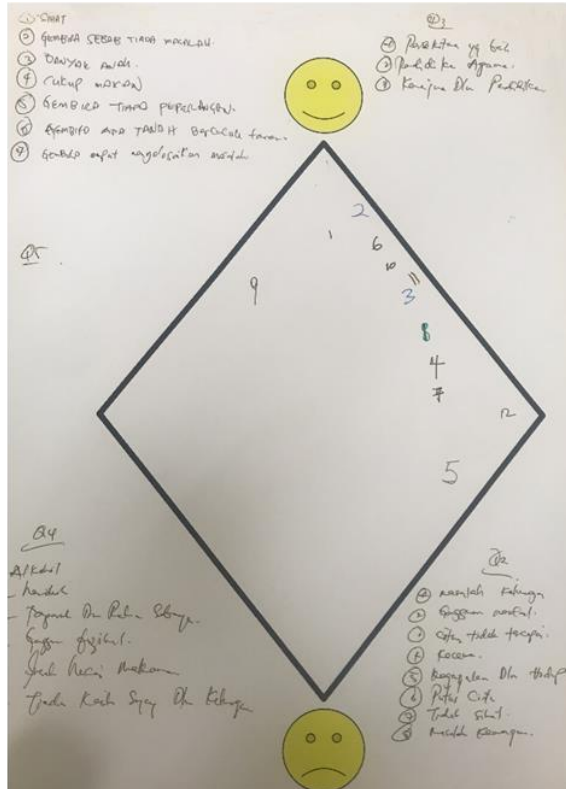


Figure 2 Example of Diamond Dialogue

The sessions were not recorded because we did not want to inhibit responses in this initial stage. Notes were taken by the facilitators in response to the questions. A thematic analysis of the responses was conducted, using a ‘bottom-up’ inductive approach⁸. The position on the diamond shape was analysed by overlaying an 11-point grid based on the Personal Well-being Index (PWI)⁹, 10 corresponded to the highest level of happiness and 0 corresponded to the lowest level of happiness. Written consent was obtained at the initial stage of the project, which included both quantitative and qualitative components. Prior to the focus group, oral consent was used to confirm that they still wanted to be involved in the project. The project was given ethical approval by the Ethics Committee at Universiti Malaysia Sabah (JKEtika2/12(1)).

RESULTS

In the first workshop, talks about alcohol were held, followed by a small group discussion. It was difficult to start the conversation about alcohol use in some of the male groups, who were hesitant to engage with the team. During these groups the participants were asked why (without asking if) they wanted to change the alcohol-related culture in their village and how this might be done. It became apparent that participants believed that there were positive effects of alcohol in the community and on their quality of life. For example, one of the male groups clearly expressed that they did not want to change the alcohol culture because there were few other things to do in the village. The women’s group and children’s group were more open in talking about alcohol-related harm in their village, particularly in relation to relationship difficulties and domestic violence. The second workshop started with the small group discussion using the Diamond Dialogue. The themes discussed are described to illustrate how this lead to discussion about community level change to reduce alcohol-related harm. Five main themes were found in answer to the questions about what makes people happy

and unhappy. These were named: Family and relationships, Security, Health, Expanding horizons and Religion; which overlap partially with the eight domains of the PWI. Alcohol was a topic that pervaded all of these themes, with positive and negative effects being recognized by participants.

Family and Relationships

This was the first theme that emerged in most groups and appeared to be the most important. People generally expressed satisfaction in their relationships. Family relationships were mentioned most frequently, with relationships with others mentioned very little. Children were a source of both happiness and unhappiness, with people expressing dissatisfaction with children not listening to them or arguing with each other. Grandchildren appeared to only be a source of happiness, not unhappiness. Some of the male participants mentioned that they were happy because they did not have children.

Alcohol was also mentioned in both positive and negative light in this category. People talked about alcohol improving social connectedness and social events, making them more outgoing generally. One of the women's groups talked about the husband drinking too much being a source of unhappiness including fighting and domestic violence. One of the male groups talked about alcohol breaking up families.

Security

Financial, physical, environmental and role security were part of what it meant to be happy. Having no debt, home ownership, a safe environment, adequate resources and being free from external threats were a source of happiness. They saw unemployment, having debts, poverty, inadequate food, a broken down car, less facilities, floods and accidents as being sources of unhappiness. They were worried about the future security of their children, and who would care for them if they got sick or died. Alcohol was seen as part of the culture and

the men's group implied that modern health promotion (including the alcohol harm reduction event that was being run that day) was a threat to their cultural security. The women's group talked about how the cost of alcohol was impacting on the money available for their children's education. The women discussed their frustration about the men not being able to do anything when they are drinking and compromising their economic security through loss of wages and wasted resources.

Health

Health was seen as essential to happiness, for both themselves and their children. This theme mainly emerged when talking about reasons for unhappiness, rather than reasons for happiness, implying that it is something that is taken for granted by the people who were healthy.

They believed alcohol was both a source of poor health and good health. Some of the men described alcohol use as being a successful coping mechanism, which helped them to deal with problems. The women talked about concern about the men's drinking leading to health problems and the men were worried about overuse leading to hangovers.

Flourishing (Expanding Horizons and Having Fun)

This category emerged as being different, in that it was not about maintaining what had already been attained, but about developing new aspirations and experiencing the joy of life. This included success in school, business and work. Travel, socialising with friends, meeting new girlfriends and voluntary work were also discussed. One group also discussed empowerment, in that they were able to solve their own problems.

Alcohol was again seen as a positive and a negative in this category. Both male groups believed that alcohol was very much a part of having fun and social events without alcohol

were seen as dull. One male group expressed that alcohol was a key ingredient in their quality of life, in that their life would be very dull without it. The male group also acknowledged that alcohol could impair their aspirations if used excessively.

Religion

Religion was a key source of happiness for both male and female participants. They described praying and going to church as contributing to their happiness. They did not mention religion as part of their unhappiness. They did not mention religion in relationship to alcohol. The participants in the focus groups were all Christians.

Positioning on the Diamond Dialogue

The range of values on the Diamond Dialogue was between 10 and 3.8 with a mean of 6, which is slightly less than the average for most countries on the PWI⁷. In two of the groups there was a variety of responses, and in the other two groups most of the responses were clustered around the midline, meaning neither happy nor sad. The mean scores for the female groups were 5.3 and 5.8 and for the male groups 5.7 and 7.1. These findings need to be placed in the context of cross-cultural research on differential attitudes to expressing happiness and satisfaction which points to clear patterns of cultural bias^{10, 11}. The set points which individuals use to evaluate their lives tend to be much lower in the Asian context than in Western countries because of philosophical, cultural and religious traditions which discourage expression of exhilaration and exuberance in favour of contentment and harmony. Furthermore, standard deviation of results also tends to be lower as it is also not acceptable to express too much sorrow and dissatisfaction. Thus respondents tend to 'head for the middle ground'¹¹.

Therapeutic Effect

The Diamond Dialogue acted as an icebreaker in the workshop, allowing participants to express

themselves openly and creatively. The initial defensiveness towards the perceived mission of the project changed during the Diamond Dialogue session, when the participants realised that this was not a prohibition exercise and that their beliefs about the positive aspects of drinking were acknowledged and accepted. The facilitators reported a difference compared to previous workshops, which had started off with talks and were more didactic. During the workshops where the Diamond Dialogue had been used, the participants also stayed until the end of the five-hour workshop and were enthusiastic until the end. After the Diamond Dialogue, the participants were taking part in discussion and asking questions during presentations. At the end of workshops, participants were normally asked what they would like to do to change the drinking culture of their village. In previous workshops, only a minority of people took part in this discussion. This workshop was noticeably different in that most of the people present were actively involved in discussion and many more ideas were generated. These ideas focused on the ways to reduce the harm related to alcohol, rather than stopping people drinking altogether. The previous discussion regarding both the positive and negative effects of drinking lead participants to conclude that the amount that the community was drinking needed to be reduced. Drinking in small amounts lead to the positive effects, but drinking in large amounts was what leads to the negative effects. This then prompted discussion on ways to encourage community members to drink in reduced amounts. After finding the technique was useful in this workshop, it has been used in subsequent workshops, with similar outcomes.

DISCUSSION

The Diamond Dialogue started a conversation about quality of life and the importance of alcohol in the villages in which it was used. These conversations were notably more open than the conversations that we had previously

attempted to start. Alcohol was seen as something that could both improve or reduce quality of life, depending on how it was used. In using the Diamond Dialogue as a research tool, we discovered that it was useful as a tool to explore the collective ambivalence about the role of alcohol in the community. The explorations of this ambivalence lead to collective decision making regarding change in the community as a whole. Part of this decision making was discussion about ways to change the community in line with harm reduction.

What was done at a collective level is parallel to what is done in motivational interviewing at an individual level. In motivational interviewing, ambivalence is actively explored and positive and negative views about substances are accepted. The therapist adopts a neutral stance, and accepts that there may be positive effects of the substance on the client's life. In our workshops, both the positive and negative effects on quality of life in the community needed to be accepted, before any discussion about alcohol-related harm could take place. The participants in this study talked about alcohol having both positive and negative effects on most dimensions of their well-being. This is not normally acknowledged in health promotion efforts in Malaysia, which tend to focus on harm. In this workshop, ambivalence was accepted as normal and was worked with. Prochaska and Diclemente (1983)¹² discussed the stages of change that individuals pass through, including pre-contemplation, contemplation, ready for action and maintenance. In the workshops where the Diamond Dialogue was used, the groups could be seen as collectively moving from the pre-contemplation/ contemplation stages to the ready for the action stage (community action).

In health promotion theory and practice there is a tension between (1) 'healthy lifestyle' approaches that aim to persuade individuals to change their health-related behaviour and (2) 'social determinants' approaches that aim to create healthier environments through systemic strategies, rather than encouraging individual

change. The first approach is criticised for essentially 'blaming the victim', whereas the second approach can be criticised for being top-down and disempowering, since it disregards individual agency. The Diamond Dialogue approach is a 'healthy environment' approach, in that the social environment changes. However, agency is not removed. Significant numbers of individuals in the community are involved in decision making. Using the Diamond Dialogue in this way shifts the agency from the individual to the community. The decision for community action is made by a collective consciousness, rather than individuals. This decision then leads to a change in the social environment of the community as a whole. Gillies (1998)¹³ reviewed community partnership initiatives in health promotion and concluded that genuine community engagement is difficult and frequently only involves people at the top of social hierarchy. Clarifying community values and making a decision together enhances social capital.

The enduring basic principles of health promotion are similar to the core principles of these individual therapies. Collaboration, equality, finding common ground and setting common goals have always been¹⁴, and continue to be¹⁵, considered key ingredients in ensuring successful health promotion. In addition, The Shanghai Declaration (WHO, 2016)¹⁵ reiterates the sentiments of the Ottawa Charter (WHO, 1986) by emphasizing that 'empowering people to increase control over their health and ensuring people-centred health systems' is the only path to sustained health and well-being. However many community interventions are similar to the first workshop we conducted, in that direct confrontation and specific focus on harms is used. This is likely to lead to the same effects as when direct confrontation is used in individual therapy. Studies have shown that therapists that get into conflict with clients have less favourable outcomes¹⁶. If direct confrontation is used, clients tend to defend their current position and resistance to change increases, which is what we noticed in the first community based workshop. In motivational interviewing,

the therapist avoids any argumentation with the client, but accepts the client's point of view and "roles with resistance"¹⁷.

Strengths and Weaknesses

This is a preliminary report on a new intervention for communities, discovered while using the tool as a research technique. This study was not designed to specifically look at the effectiveness of this intervention and further research is required to do this.

CONCLUSION

Despite knowledge of factors that are important to health promotion, there are few practical techniques that will lead to motivation to change at a community level. The Diamond Dialogue technique is promising, with this project showing that ambivalence can be explored, change talk and action elicited and common goals set in terms of reducing alcohol related harm. It enhances health literacy which 'empowers individual citizens and enables their engagement in collective health promotion action' (WHO, 2016:1). Further study and research is needed to explore whether this technique is more effective than traditional techniques of health promotion.

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CONFLICT OF INTEREST

The authors declare that they have no competing interests in publishing this paper.

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