

Mass and Interpersonal Communication: Buzz for Behaviour Change

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Publicists, marketers, public relations gurus, and producers all try to establish “buzz” about their products **by creating media campaigns designed to generate discussion among peers**. Buzz can be an end point on its own, but it is also thought **to encourage people to buy products or adopt behaviors**.

Scholars have studied the interaction of mass media and interpersonal communication since at least Lazarsfeld’s pioneering work in the 1940s [1]. We may not know much about how media and interpersonal communications interact, but below are some of the theories and their implications for designing health communication campaigns.

Opinion Leaders

The first attempt to formulate a model was the two-step flow hypothesis by Katz and Lazarsfeld [6, 7]. The two-step flow hypothesis posited that the media influence opinion leaders who in turn influence others who are less attentive to media communications. Usually, these others are thought to be family, friends, co-workers, and perhaps acquaintances, people with whom they are close and have strong credibility and trust.

Opinion leaders were found to consume more media and were more aware of current events. In order to persuade others to follow their opinions, they used media communications to buttress their arguments. According to Gladwell [5], these “mavens” use the media to stay up-to-date on their favourite topics, they freely share this information with others, and they are seen as credible sources of this information.

This, however, may be an oversimplification. **It may be that media influence opinion leaders who influence others who then influence others – a two-step or even multi-step flow**. Further, it may be that some opinion leaders influence one or a few others, while some have much higher multiplier effects, influencing five, ten, or even hundreds of others.

These models, however, neglect to consider a number of other factors regarding the media influence process.

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Social networks have been documented as important influences on behavioral decisions ever since the classic 1943 study of factors that influence farmers’ adoption of new technology [2]. Rogers’ [3] diffusion of innovations research has shown that for a wide variety of behaviours and populations, interpersonal influence continues to be the most significant single factor influencing a person’s decision to accept new ideas and practices. Others have shown that creating “buzz” about products helps to get them purchased [4, 5]. Indeed, after people become aware of a new product, they’ll probably discuss it with someone to find out if they’ve tried it and, once they themselves try it, if they like it they’ll tell others. For more evidence that interpersonal communication is important in behaviour change, please see the additional resources listed at the end of this article.

First, it is likely that **opinion leaders are influenced by others, as much as others are influenced by them, and that the media shapes their messages in accordance with what they think the audience wants to hear.** In sum, to simply say that A influences B may be stretching it a bit, when in fact B also influences A.

Second, individuals are embedded within complex social network structures. Some people have small networks while others have quite large ones. Some social networks are dense (i.e., their friends know each other) while others are sparse (i.e., their friends do not know one another). Also, **the degree of similarity or difference between a person and his/her social contacts affects the flow of ideas and behaviors.**

Finally, there is variation in risk taking and risk avoidance in the population. **The amount of influence required for a person to adopt a behaviour varies.** Some people will adopt new behaviours when only a minority of their friends or the population has done so; others wait until a practice is widely accepted before they are willing to adopt it.

These factors show that the relationship between mass media and interpersonal communication is complex. Unlike the simple models discussed earlier, it is likely that people attend to media communication and then interpret and talk about it in unanticipated ways.

Anti-drug campaigns are a good case in point: one study, for example, found that talking about anti-marijuana ads led youth to report more pro-marijuana beliefs than did youth who did not discuss the ads with others [11]. Similarly, prolonged exposure to anti-drug ads and discussion of the ads with peers may lead youth to perceive the messages as boring or laughable [12–14].

In other words, the effect of media communications on individuals is a function of how the messages are interpreted within the context of people's social networks – how, with whom, and in what ways the messages are discussed. As David et al. [11] put it, if “messages encourage discussion among peers, and such discussion in turn leads to negative effects, then a media campaign can result in substantial deleterious effects, perhaps especially among the segment of the population most likely at risk” [p. 136].

So if the relationship between media and interpersonal communication is so complicated, how can we design health communication messages that create not just buzz, but *the right “buzz”*?

The answer probably lies in

- ❖ **mapping social networks to identify truly trusted and credible opinion leaders;**
- ❖ **conducting formative research, particularly with opinion leaders; and**
- ❖ **rigorous pre-testing with social networks.**

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In his book *The Tipping Point: How Little Things Can Make a Big Difference*, Malcolm Gladwell [5] talks about how ideas, trends, or behaviours can become “social epidemics” and the ways in which they spread throughout a society. He argues that social epidemics “tip” – that is, get underway – when three circumstances are present: the involvement of a few well-connected and persuasive individuals (“connectors,” “mavens,” and “salespeople”), a memorable and persuasive message (“stickiness”), and favourable social contexts (“the power of context”). Social trends, ideas, or behaviours spread throughout an audience and are adopted by that audience through this process of “buzz.” [For reviews of Gladwell’s book, see 8, 9, 10].

Validated Techniques to Identify Opinion Leaders

As discussed above, opinion leaders can be important in creating “buzz.” The trick is identifying true opinion leaders – those that are trusted and credible. Many opinion leaders are self-selected or identified by project staff with no knowledge of whether they actually act as opinion leaders for members of the intended audience.

Valente and Davis have begun work on a system that matches audience members to the leaders they nominated [16]. Figure 1 shows an example of how, in a small network, leaders can be identified as those who receive the most votes as a leader and then groups are constructed by assigning people to the leaders they nominated. After asking community members to identify opinion leaders (normally in the context of a specific topic), the process has three steps [16]:

1. Identifying the 10% of individuals who received the most nominations by the community members. These individuals become the opinion leaders.
2. Matching the leaders with the community members, with each individual being assigned to the leader he or she nominated, or to the leader she is most closely connected to.
3. Assigning community members who did not nominate any leaders or those whom no one nominated in a random fashion or assigning them proportionally to the more popular opinion leaders.

This process provides “an optimal matching of opinion leaders to the community members who look to each of them for advice and thus can be used to accelerate the diffusion process” [16, p. 60].

A relatively recent study validated this approach. In a peer-led smoking-prevention school program, it was found that students who were matched with their nominated opinion leaders enjoyed the program more, had improved attitudes and self-efficacy, and reported decreased intention to smoke than did students randomly assigned to leaders or those assigned to leaders by their teachers [17]. The intervention consisted of 8 50-minute workshop sessions, which included discussions, role-playing exercises, and interactive games.

An alternative approach, also shown to be effective, is to define groups first and then select leaders within these groups [18]. While it may be more efficacious for participants themselves to nominate peer leaders [16], this approach may not always be appropriate or feasible for the intervention and audience in question. Thus yet another approach is to have “key informants” identify opinion leaders. For example, Kelly and colleagues [19-21], in their peer-led HIV intervention, asked bartenders in gay bars to observe their bar patrons for 10 days and indicate the names of those who they thought were the most popular with the other men. The lists were then cross-checked and names appearing on more than one list were recruited for training as peer opinion leaders.

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Evidence shows that who delivers the message and to whom is just as important as the actual message itself. For example, a recent meta-analysis was carried out on 94 studies related to substance abuse prevention in school settings [15]. It showed that programs which used peers to deliver health messages were far more effective than those which did not use peers or those which used a combination of teachers and peers to deliver the messages.

In the work by Kelly and colleagues [19-21], opinion leaders worked their risk reduction messages into natural conversation with their peers. The peer leaders personally endorsed these messages, thereby lending their familiarity, popularity, and credibility as peer leaders to the messages themselves and helping to influence norms about safer sex behaviour. The programs were sustained by training successive waves of peer leaders. Their interventions, based in gay bars in small US cities, helped reduce risky sexual behaviour by almost 30% from their baseline levels [22, p. 140]. This approach is in contrast to matching leaders to persons who nominated them as leaders, which may not be possible in less structured environments, such as a gay community, as opposed to in a classroom setting.

Formative Research

Health communication practitioners already know the importance of formative research, i.e., analyzing the target audience to secure an in-depth understanding of how they view the issue at hand. At a minimum, it involves assessing their barriers and incentives for behaviour change as well as their language, cultural cues, and beliefs about the world.

If practitioners are designing messages meant to stimulate “buzz,” this research should include focus groups with opinion leaders, identified by the methods noted above, to help design messages that engage opinion leaders in a way that inspires them to talk about the message and that are correctly understood by the opinion leaders.

Pre-testing with Social Networks

Like formative evaluation, pre-testing draft health communication materials to determine whether they resonate with audiences, and in the right way, is not a new concept to seasoned practitioners. However, to ascertain the potential for the right “buzz,” pre-testing should be done by exposing people to communications with members of their social networks and encouraging them to discuss what they’ve seen or heard.

Focus groups are a particularly useful method of investigating exactly how people discuss a health message [25]. Focus groups with opinion leaders and their “ties” (as identified by mapping) would also be useful to see whether they talk about the messages in the right ways. At a minimum, in cases where such a mapping has not been conducted focus groups should be conducted with people who know one another to determine how they discuss the topic, what they say, and to whom. In either case, it is important to understand the ways in which people discuss the health message to ensure that the message brings about the intended and expected discussion.

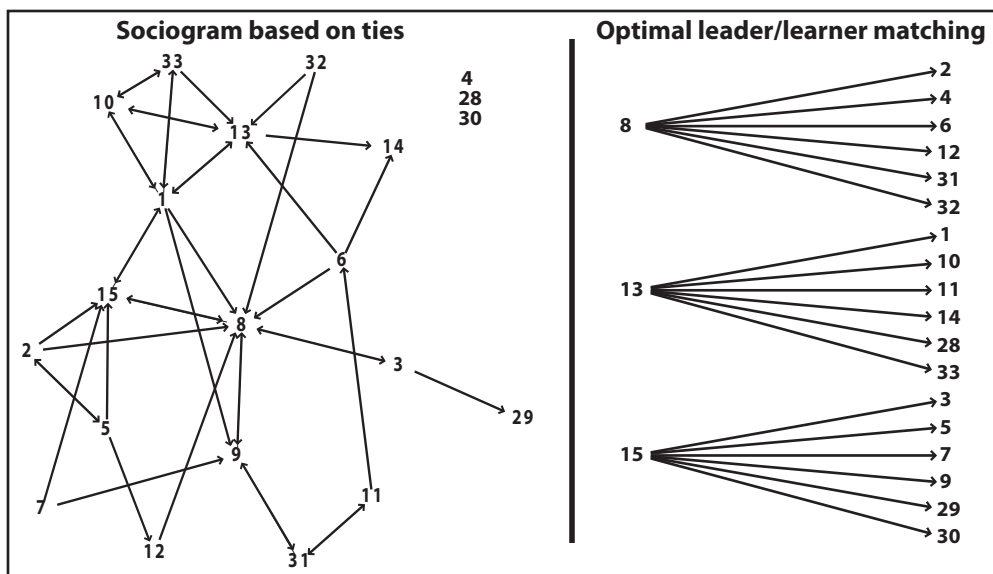
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The ideas of “strong” and “weak ties” are typically traced to the work of sociologist Mark Granovetter [23, 24]. He reasoned that “strong ties” are those with whom we spend much time, have strong emotional bonds, and do things for each other: in short, those we might consider **close friends** and who are **likely to know one another**. “Weak ties,” on the other hand, refer to those people we consider **acquaintances** and who are **unlikely to know one another**. He argued that weak ties act as bridges between dense social networks (such as our own social networks and those networks that our acquaintances are part of). These bridges are extremely important, he argued, because they permit the flow – or “diffusion” – of information between social networks. In other words, information, ideas and knowledge can be transmitted between dense social networks through the bridges between members of each network.

Conclusion

As we have discussed, the effectiveness of all health messages depends on how and with whom they are discussed. Creating the right “buzz” requires a few important steps:

1. **mapping social networks to identify truly trusted and credible opinion leaders;**
2. **conducting formative research, particularly with opinion leaders; and**
3. **pre-testing messages with social networks, or at least with groups of people who know each other.**

In the commercial marketing world, Silverman [25] recommends an approach like this. He talks about using focus groups comprised of experts, opinion leaders, and peers to investigate the nature of “word of mouth” among them. In reviewing the health promotion literature for this article, however, we did not find any examples of formative research that had been conducted with opinion leaders and their “ties” to see how health messages were discussed. We are very interested in hearing about examples of this from our readers!



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Figure 1. Social network of physicians in one community in Illinois in the mid-1950s from Coleman and others [26]. Optimal assignments based on leaders being assigned to those who nominated them or are “closest to” in the network [16].

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Additional Resources

The role of interpersonal communication in behaviour change

Academic

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The unintended effects of health communication

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Electronic

Word of Mouth Marketing Association (WOMMA): www.womma.org

The trade association of those in the "word of mouth" marketing industry. Be sure to check out the "Womnibus," their research blog, as well as their compendium of other related blogs net-wide. They also offer some excellent e-newsletters on latest developments in word of mouth marketing.

Social Marketing Listserv

Anyone interested in social marketing should subscribe to this list started by Georgetown professor, Dr. Alan Andreasen. The listserv is a forum for talking about social marketing research, practice, and teaching. To join, subscribe to istproc@listproc.georgetown.edu through email and type **subscribe soc-mktg** in the message body. (Compliments of The Health Communication Unit, University of Toronto)

On Social Marketing and Social Change: socialmarketing.blogs.com

A blog run by R. Craig LeFebvre, Ph.D., a leading expert in social marketing and social change. A good place to keep up with recent developments in social marketing, including postings on social networks.