Flora Cornish and Alex Gillespie

A pragmatist approach to the problem of knowledge in health psychology

Article (Submitted version) (Pre-refereed)

Original citation:
Cornish, Flora and Gillespie, Alex (2009) *A pragmatist approach to the problem of knowledge in health psychology.* *Journal of health psychology*, 14 (6). pp. 800-809. ISSN 1359-1053
DOI: 10.1177/1359105309338974

A pragmatist approach to the problem of knowledge in health psychology

Abstract

The multiplicity of forms of health-related knowledge, including biomedical knowledge, lay knowledge, and critical constructionist knowledge, raises challenges for health researchers. On one hand, there is a demand for a pluralist acceptance of the variety of health-related knowledge. On the other, the need to improve health calls for action, and thus for choices between opposing forms of knowledge. The present article proposes a pragmatist approach to this epistemological problem. According to pragmatism, knowledge is a tool for action and as such it should be evaluated according to whether it serves the desired interests. We identify implications for research methodology and the choice of research goals.

Keywords: pragmatism; epistemology; medical knowledge; lay knowledge; methodology

Abstract word count: 105

Total word count: 6,376

Working in the context of complex real-world health problems, health psychologists encounter the challenge of a multiplicity of conflicting forms of knowledge. Take an example of working to prevent HIV transmission in the context of commercial sex (e.g. Campbell, 2003). Biomedical knowledge about risk factors and transmission routes suggests promoting condoms to sex workers. After some qualitative interviewing, it emerges that, according to local knowledge, condoms are for casual sexual relationships and thus the absence of condoms in a regular relationship signals closeness and trust. In this situation, emphasising the medical risks of commercial sex may actually exacerbate the risks in the sexual relationships with regular partners. Finally, after some critical reflection, stimulated by theoretical knowledge of 'victim blaming' and stigmatisation, a researcher might question the ideological assumptions and social effects of targeting the sex workers rather than their clients. In this example we see three forms of knowledge collide, with each indicating a different intervention. How should health psychologists judge the value of each form of knowledge?

The epistemological assumptions of health psychology research have traditionally been framed as a choice between the realism of 'mainstream' health psychology and constructionism, often associated with 'critical health psychology' (e.g. Crossley, 2000a). Neither of these approaches has convincingly provided the right answer to health psychology's epistemological questions (Marks, 2002). On one hand, the immediacy of suffering and inequality call for effective action and improved health outcomes, traditionally associated with a realist epistemology. On the other hand, health issues are

replete with political and moral dimensions and thus call for nuanced constructionist critique (Yardley & Murray, 2003). Realism tends to prioritise a single form of knowledge as 'true', thus being insensitive to alternative forms of knowledge, while the relativism associated with constructionism makes it difficult to give definitive recommendations for effective action. Is it possible for research to be pluralist about knowledge, but at the same time non-relativist and promote positive social action?

In the interest of contributing to the ongoing debate about the philosophy, scope, values and methodologies of health psychology (Crossley, 2000a; Hepworth, 2006; Marks, 2002; Murray & Campbell, 2003; Prilleltensky, 2003), this article introduces a pragmatist philosophical perspective. Pragmatism, we shall argue, avoids the problems of realism and relativism and enables both critique and action.

The problem of knowledge in health research

Awareness of the plurality of knowledge is part of the 'postmodern condition' (Lyotard,1984), in which 'Grand Narratives' are no longer convincing. The juxtaposition, in the global age, of multiple contrasting beliefs undermines our confidence that Science, Religion or Philosophy holds the key to that which is True or Good. Historical studies, such as Foucault's (1967) pioneering work on scientific discourses of mental illness, have shown the power-laden effects of highly contingent, yet so-called scientific, knowledge. Developing this approach, constructionist researchers have questioned the dominance of biomedical discourses (e.g., Crossley, 2000a), the governmentality of health promotion policies and messages (e.g., Sykes, Willig & Marks, 2004), and the

particular ways in which research methods such as randomised controlled trials and systematic reviews construct knowledge (Moreira, 2007). Such questioning has been complemented by alternative positive programmes of research, including the development of qualitative research methods (Camic, Rhodes & Yardley, 2003a), and research interests in other knowledges, such as community and service user perspectives (Foster, 2007; Fryer & Fagan, 2003).

However, the constructionist perspective has itself been subjected to critique (Murray & Campbell, 2003; Hepworth, 2006). Two major charges are of particular relevance here. Firstly, a constructionist position, which claims that all knowledge is constructed from a particular ideological, social or personal position, undermines claims that any one of these constructions is definitively morally or epistemologically superior to another. Constructionism's critics argue that such relativism is not defensible for a morally responsible science. It is argued that local knowledge is sometimes simply wrong or even oppressive (Prior, 2003). In refusing to adjudicate between 'local truths', critics argue, constructionism accepts oppressive or false beliefs, and fosters individualism and fragmentation (Ratner, 2006). Secondly, constructionism is criticised for neglecting social action and positive programmes for intervention (Murray & Campbell, 2003). Analysis of discourses plays a crucial critical role in revealing the workings of power in society, but such analyses rarely lead to specific implications for health-enhancing action (though see Willig, 1999, for an exception). The pressing challenge for critical health psychology,

according to Prilleltensky (2003, p.2), is ‘to offer alternative practices that go beyond the status quo and its critique’.

Pragmatism, we shall suggest, takes us beyond the realism-constructionism divide, providing a productive approach to evaluating health-related knowledge. Pragmatism acknowledges the plurality of knowledges and provides for critical analysis, but, by focusing on the purposes and consequences of knowledge, allows for non-relativist positive social action. We first outline the pragmatist perspective and then turn to consider some of the consequences of pragmatism for health research.

Pragmatism: Knowledge as a tool for action

Pragmatism originated over a century ago with the American philosophers Charles Sanders Peirce, William James, John Dewey and George Herbert Mead. Unlike realism, pragmatism does not rest upon ambitious claims about knowledge reflecting an underlying reality. Unlike idealism, it rejects the idea that the mind is the basis of knowledge, and directly opposed to rationalism, it disagrees that abstract rationality is the path to reliable knowledge. For pragmatism, it is practical activity that is the bedrock and the test of knowledge. Knowledge is judged according to its consequences in action. Recently there has been a surge of interest in pragmatism, in philosophy (Kloppenberg, 1996), social theory (Baert, 2004), law (Posner, 2003), medical ethics (Hester, 2003), education (Biesta, 2007), and public administration (Shields, 2003), but as yet, it has had little impact in psychology or in health-related research.

The pragmatist approach to the problem of knowledge is to change the question that we ask about knowledge. Instead of asking ‘Does this knowledge accurately reflect the underlying reality?’ the question becomes ‘Does this knowledge serve our purposes?’ (Rorty, 1999). The roots of this shift lie in a critique of the Platonic idea of Truth. According to Plato, beyond our flawed human perceptions, there exists an almost heavenly and timeless realm of ‘ideal forms’ which comprise Truth. In Plato’s allegory of the cave, human perceptions are akin to mere shadows on a wall, cast by the real ideal forms outside the cave. This Platonic conception of Truth was carried forward by philosophers such as Descartes (Gillespie, 2006), and underlies contemporary variants of realism. Realism adheres to a correspondence theory of truth, maintaining that there is a reality ‘behind’ appearances, and that true knowledge is knowledge which corresponds to that reality.

Pragmatism strongly rejects the correspondence theory of truth. For pragmatists, knowledge is not a representation of reality or a ‘mirror of nature’ (Rorty, 1981). Rather, it is a tool for action. Rather than mirroring reality, knowledge mediates our relation to the physical and social world. Pragmatists argue that there is nothing extra to be gained by positing a reality ‘behind’ appearances and worrying about whether one’s statements represent that reality (Rorty, 1999). Lay people and scientists alike construct knowledge in the context of action: knowledge guides action and action feeds back into knowledge construction. Thus, for pragmatists, the only sensible yardstick by which to judge a piece of knowledge is whether that knowledge is useful for a

given interest. A hammer is useful for striking nails just as knowledge of antibiotics is useful for dealing with bacterial infections, and knowledge about complementary medicine is useful in cultivating a feeling of wellbeing. None of these tools can be said to ‘better reflect an underlying reality’, rather, each tool serves its particular purpose.

Rorty (1998, p.48) captures the radical novelty of the pragmatist approach when, in his characteristically provocative way, he states that our vocabularies and concepts ‘have no more of a representational relation to an intrinsic nature of things than does the anteater’s snout’. The anteater’s snout is an adaptation to its environment, which mediates between the anteater’s desire for ants and the existence of ants in hard to reach places. The ‘goodness’ of the snout can be judged accordingly. Just as the anteater’s snout is not a mirror of ants in hard-to-reach places, human knowledge of horticulture and animal husbandry is not a mirror of plants and animals. It is a purpose-driven mediator between the human desire for food and the world as we find it. Its usefulness is judged, not by whether it ‘mirrors’ reality, but by whether it successfully enables humans to achieve their various individual and collective interests.

Pragmatism’s focus on usefulness is sometimes interpreted (and criticised) as narrow utilitarianism – a position that knowledge should serve very practical purposes, or should enable the smooth functioning of society. However, this is misleading. While one might be able to reduce the anteater’s use of a snout to reproduction, human interests are much more varied, and may extend from

disturbing the smooth functioning of society to controlling nature, from poetry to convincing consumers to purchase cigarettes, and, importantly, from individual interests to collective interests. Indeed, it is the recognition of the great variety of human interests which makes pragmatism pluralistic (James, 1977).

The rejection of reality behind appearance does not leave pragmatism in a relativist quagmire. The existence of activity – mundane here-and-now practical action – is undeniable. While correspondence theories of truth prioritise reference to reality, considering activity and experience as imperfect reflections of this reality, pragmatism inverts this hierarchy, placing human activity as primary, and considering talk of reality 'behind' experience as speculative, vague and untrustworthy. Thus, the criteria for judging good knowledge are in whether it works to solve the problems of everyday action.

Pragmatism is pluralist (like constructionism), in that it accepts the variety of competing interests and forms of knowledge. Accordingly, it is also critical, in that its focus on the interests served by knowledge invite questioning of whose interests are being served. However, it is non-relativist, in that knowledge can be evaluated by reference to its ability to facilitate successful action. It is action-oriented, in that everyday problems and actions are the primary reality, and the test of our knowledge.

Thus far, we have outlined the epistemological position of pragmatism regarding the nature of knowledge. But the discussion has been abstract,

focusing on assumptions rather than consequences, and hence not, in fact, pragmatist. We now turn to putting pragmatism to its own test of having consequences for action, considering its consequences for the choice of research methods, and the choice of interests to pursue.

Choosing research methods: Hierarchy of evidence or diversity of interests?

Health psychologists are engaged in a wide range of knowledge-making practices, including randomised controlled trials (RCTs), surveys, narrative analysis, discourse analysis, action research and theoretical work, among others. Researchers in these different traditions argue over the relative merits of their approaches, some arguing for the importance of prediction and control, while others argue for the value of understanding meanings. Arguments between these different approaches are implicitly predicated on the non-pragmatist question: Which form of knowledge-making brings us closest to the 'Truth'?

The dominant way to answer this question has been to propose a 'hierarchy of evidence' to order the different methods (e.g., Evans, 2003; Harris *et al*., 2001). The 'hierarchy of evidence' tells us that systematic reviews of RCTs are the most valuable forms of evidence, followed by individual RCTs, uncontrolled studies, cohort studies, descriptive and case studies. This hierarchy prioritises experimental, quantitative methods, and de-legitimises case studies or qualitative methods. The hierarchy has been critiqued in

critical health literature, on the basis that RCTs fail to elucidate the *processes* through which outcomes were produced (Clark *et al*., 2007; MacPhail & Campbell, 1999), and are insensitive in instances of complex, multiply-determined, socially-situated health issues (Clark *et al*., 2007; van de Ven and Aggleton, 1999).

A pragmatist approach adds a helpful frame to such critiques, arguing that there is no absolutely 'best' method, but each method is good at achieving particular ends (Baert, 2004; Camic, Rhodes & Yardley, 2003b). To make a judgement about the relative merits of the diverse knowledge-making practices, a pragmatist would first ask: In relation to which interests are we judging these practices?

RCTs are particularly suitable for determining which of a limited number of interventions is most effective at producing a pre-determined health outcome within a specific stable context. They answer to scientific interests in comparing the effects of different pharmacological treatments, or other clearly-defined interventions, and to health professionals' interests in choosing between treatments. RCTs are excellent means of achieving these particular ends, but these are not the only ends that may be served by health research. Indeed, to place RCTs at the top of the hierarchy may be to prioritise certain interests, and thus, an exercise of power, rather than a reflection of an objective hierarchy among methods.

The expansion of ‘Evidence-Based’ approaches, with their hierarchies of evidence, beyond medicine, to the now popular notion of ‘Evidence-Based Policy’ points to a key interest served by such hierarchies: the interest of policymakers and managers in being able to justify their decisions (Dobrow *et al.,* 2004). Claims about the evidence-base for the allocation of scarce resources lend decisions the rhetorical power of accountability, transparency and fairness. Perhaps the usefulness of RCTs for making justifiable policy decisions is the reason for their being placed at the top of the hierarchy.

This is not to suggest that research ought never to serve such managerial interests. But it is to be more specific about what interests RCTs serve. Presenting RCTs as the ‘gold standard’ for research obstructs the pursuit of alternative interests, and de-legitimises the best methods for meeting these alternative interests. We will consider three alternative interests: knowledge for taking care of oneself, knowledge for intervention design, and knowledge for cultural critique.

Knowledge for taking care of oneself

Health education has been soundly criticised for taking biomedically accurate information (such as that provided by RCTs) and assuming that if lay people are provided with this information, and think rationally, they will act appropriately (e.g., Campbell, 2004a). From a pragmatist point of view, the key issue is that biomedical knowledge is often not very useful or actionable in relation to the needs of lay people. In situations where people have been diagnosed with a chronic illness, meanings, as much as facts, comprise useful

knowledge (Crossley, 2000a; Krause, 2003). An illness can change the meaning of a person's life, their relationships, their work, and their very self. In creating their health identities, lay people may draw on medical, non-medical, or even anti-medical knowledge (Fox & Ward, 2006). Accordingly, service users have needs for knowledge much broader than biomedical knowledge. While RCTs provide service users with important information about appropriate medical treatments, they offer few resources for the tasks of making sense of illness and forging a new identity.

Even for relatively clearly defined objectives, such as protecting sexual health, giving up smoking, or exercising, actionable knowledge often comes in the form of strategies and skills, not medical facts (Lyles *et al*., 2007). For example, role play may be used to develop young people's sexual negotiation skills, so that they are equipped with interpersonal skills and discursive strategies enabling them to deal with situations where they feel under pressure to have unprotected sex (Laub *et al.,* 1999). At meetings of Alcoholics Anonymous, people actively share strategies for avoiding alcohol consumption (Makela *et al*., 1996). They suggest to each other to avoid certain social situations, to avoid certain friends, and to make sure that wherever they go, there are alternatives to alcohol. They also practice how to decline an offer of an alcoholic drink. In both of these examples the type of knowledge produced through RCTs takes a backseat, and instead it is everyday knowledge and social skills that prove to be most useful and enabling. The proliferation of service user groups and survivor groups is

testament to the importance of such practical knowledge, and one role for health research could be to support the construction of such knowledge.

What methodologies would health researchers employ to serve the practical interests of lay people or service users? Such research might begin with people's experiences and perspectives. Analytic procedures such as grounded theory (Glaser & Strauss, 1967), and narrative analysis (Crossley, 2000b) can help researchers to distil strategies, narratives, and heuristics which have proven useful. Strategies, narratives, and heuristics are not true or false. They are resources which can be offered because they have worked for some people in the past. Alternatively, action research may be used to create new strategies or transform service provision to better reflect the needs of users (Krause, 2003). RCTs, on the other hand, are not designed to discover or promote skills or strategies. This is not to say that RCTs are wrong' or oppressive, but that the answer to different interests.

Knowledge for intervention design

Health intervention designers face challenges of implementation. They have to work with the complex, real-world, everyday practicalities of individuals and communities, where familial, financial, political, cultural and social dimensions are deeply entwined with health behaviour and outcomes. Programme success often depends, not only on the evidence base of the intervention, but also upon skills of ensuring acceptability to service users, commitment from healthcare workers, and support of managers or powerful local stakeholders (Campbell, 2004b; Cornish & Ghosh, 2007). RCTs may offer some confidence

that a chosen method has worked in the past, but a new context will produce uncertainties, obstacles, exceptions and dilemmas that have to be managed. We cannot expect to map out every single condition that programme designers might encounter, in an ever-changing social and historical context, and create an exhaustive RCT-backed decision tree. Rather, what programme designers need is generative, adaptive and flexible knowledge to guide them through novel situations. Theories and models can provide such flexible knowledge. Richly detailed case studies can support the development of context-sensitive expertise and skilled decision-making (Flyvbjerg, 2001).

One example of useful knowledge for furthering the interests of practitioners of community mobilisation is Paulo Freire's (1970) theory of conscientisation. The 'truth' of this theory has never been tested by an RCT, and is not amenable to such a test. As a complex social intervention, conscientisation is not equivalent to a 'treatment' to be evaluated. The theory provides a general orientation to working with communities that can be interpreted, to fit with the local context, and its utility has been confirmed by its successful usage in a great variety of settings around the world. A good model can work in a similar fashion, and Alcoholics Anonymous again provides an example, whose success has been facilitated by clear, user-friendly guidelines for the establishment and running of new groups, provided in the 'Twelve Traditions', and 'Twelve Steps', detailed in 'The Big Book' (Alcoholics Anonymous, 2007). For those who implement interventions, theories, models, and guidelines encapsulate practical experience and facilitate the design and modification of

projects. Such practical and theoretical knowledge cannot simply be evaluated at a low level on a one-dimensional hierarchy of evidence.

Knowledge for cultural critique

Finally, research may serve a broader cultural interest of stimulating new interests. Considering knowledge as constitutive of our problems and possibilities (rather than as a 'mirror of nature'), a pragmatist perspective values research activity which creates new ways of thinking and acting and thus creating a richer future (Rorty, 1999). As Biesta (2007) explains, in his pragmatist critique of demands for 'evidence-based practice' in education, RCTs are investigations of alternative means to pre-defined ends, but they do not problematise the chosen ends, or envisage new possible ends to pursue.

For health research, the ends are usually defined in terms of health outcomes, but increasing recognition is being given to competing ends, such as equality, dignity, tradition, quality of life, and ethical principles. Biesta (2007) gives the example of feminist theory, which has created new awareness of gender and opened up new important issues and problems, for educators and healthcare workers (e.g. Wilkinson & Kitzinger, 1994). Likewise, research on health inequalities (Wilkinson, 1996) highlights an interest in ensuring that the impact of health programmes is evenly distributed through the diverse groups in society. Feminism and the ideal of equity in health cannot be subjected to RCTs. Rather, these are guiding theoretical ideas which give expression to societal values.

What sorts of methods produce ideas for ‘what might be’ rather than ‘what is’? Comparative methods, such as Foucault’s genealogical method (e.g. Foucault, 1967), help to problematise current assumptions. The value of such work, it has been argued, is not so much its accurate portrayal of other cultures or other times, but its creation of a new point for reflection upon the present (Baert, 2003), enabling critique of the present and suggesting future possibilities. For the work of developing new theories or lines of inquiry, Feyerabend (1973) suggests that methodological proceduralism may be less useful than imagination. Democracy, the welfare state and universal health care were ideas explored through literature and fictive utopias before they were instituted in reality.

Our argument that there are multiple interests that may be served by health research leads us to reject the idea of an absolute hierarchy of evidence. Since there is no objective way of ordering our different interests into an eternal hierarchy, no method is intrinsically better than another, though methods may be better than others in relation to particular interests. If supporting service users’ practical needs, or aiding intervention designers, or imagining alternative societal arrangements were prioritised, then theory-building or insightful qualitative analyses might be considered the ‘gold standard’, and RCTs a technical necessity, useful for deciding between comparable alternatives, but silent on the major questions. Although pluralist, pragmatism is not epistemologically relativist, since knowledge can always be evaluated in terms of whether it succeeds in serving a specific interest or not.

Choosing interests: Useful for which end?

Emphasising the diversity of interests may help to clarify the usefulness of different methods for different ends, but pragmatism, as described thus far, does not determine which of these many interests our research should advance. An individual interest might be at odds with a collective interest, as when a public health measure such as a ban on smoking in public places interferes with an individual's choice to smoke. Or an interest in fund-raising to provide better services for disabled children, and thus portraying the children as needy, may be at odds with an interest in de-stigmatising disability. If Truth is not the objective of our knowledge-making, how are we to know which interest our research should advance? Rather than identifying the content of the interests to pursue, what we need are means of collectively deciding between the variety of interests at stake. We will suggest three means that health researchers might use to inform their choice of interests to pursue.

Tackle problems defined by people's experience

The first suggestion is that we should take our direction from concrete problems in society. Pragmatism gives priority to people's everyday experience. As Rorty (1999, p. xxii) writes, for pragmatists, human inquiry is 'an attempt to serve transitory purposes and solve transitory problems.' If somebody experiences a problem, we need have no doubt that this is a real problem. We do not need big ultimate Truths in order to know what is valuable to pursue, we just need to listen to people's problems of living, and valid lines of inquiry will open up (Glaser & Strauss, 1967). This approach is well established in approaches such as Participatory Action Research and

Community Psychology, which pay careful attention to the perspectives and priorities of local people, and seek to address them. For example, Fryer and Fagan (2003), in their work with members of a community with high levels of unemployment, poverty and psychological distress, were guided by unemployed people's reports that their core problems were financial, rather than being guided by abstract academic hypotheses about psychological impacts of unemployment. Consequently, their research and action worked to address the community's financial problems and access to benefits. Taking people's problems as the starting point is not a soft option for a researcher. Their work faces the most stringent pragmatist criterion: whether it makes a difference to those problems in practice.

Choose problems through public deliberation

The second means for choosing problems relies on democratic debate. Although Rorty (1999) is adamant that pragmatism does not lead necessarily to any particular definition of the good, and can as easily be put to dictatorial as to democratic ends, it is notable that most pragmatist philosophers (including Dewey, Mead, and Rorty himself) are inclined towards democracy, liberalism, diversity, and tolerance. This is surely related to the anti-foundationalism of pragmatism. As Miller (2004, p.248) puts it: 'pragmatists think that democracy is special in that it is the only belief that does not rest upon the idea that life must be subjected to some universal standard or preemptory authority that takes priority over every lived moment.' Even if all of our knowledge is perspectival and not absolute, shaped for humans in their diversity, we still have to live together and to forge collective actions. Inclusive

public deliberation is the best means we have developed for identifying collective problems and planning collective action (Habermas, 1989; Rorty, 1999). Increasing attention to the participation of service users in health service decision-making gives greater opportunities for public deliberation over appropriate action.

Many health-related decisions call for public deliberation, such as questions about the appropriateness of stem cell research, or equality in the provision of health services, or genetic testing (Gaskell, 2004). No scientist or philosopher can provide a 'correct' answer to these issues. Health outcomes may compete with other ends such as equality, dignity or tradition. For instance, we might know that reducing contact with tuberculosis patients limits the spread of the infection, but this fact cannot determine whether closing international borders to people with TB is acceptable. Mediating between these contrasting frames for what is good is an activity for public deliberation. Likewise, at a more local level, participation of service users and communities in debate about health service provision ensures that experiential, local problems are on the agenda, and that locally appropriate solutions are generated – rather than these being determined by a single authority.

Critique the choice of interests being served

The third suggestion concerns the on-going necessity for critique of the interests served by all knowledge. Supported by the discourse of 'evidence-based practice' and 'evidence-based policy', scientific knowledge is called upon as the basis for decisions about priorities and allocation of resources (Biesta, 2007). Neo-liberal economic knowledge plays an important role in

society's understanding of itself (Nafstad *et al.,* 2007), including decision-making about health services (Pollock, 2004). Each different form of knowledge comes with assumptions about the way society works, is produced by certain social groups, and advances certain interests at the expense of others. From a pragmatist point of view, knowledge is never 'disinterested'. For knowledge to be worth pursuing, it will be in the interest of those who are using that knowledge. Accordingly, it is essential to question which interests are being addressed and which disregarded or undermined.

A critical perspective in health is often associated with an anti-biomedical stance. But the pragmatist perspective reminds us that biomedical knowledge serves the everyday interests of patients when it cures an illness, relieves symptoms, or helps a person to avoid a serious medical condition. For certain health issues, biomedical knowledge is extremely useful knowledge, and faced with a serious medical condition, many patients and their families will prioritise interests in physical wellbeing over other interests such as equity, identity, or meaning. Pragmatism does not prioritise any of these interests at the outset, but critically analyses which interests are served in a particular situation by the application of a particular kind of knowledge.

Conclusion

Our aim, in this article, has been to introduce a pragmatist way of conceptualising and evaluating the knowledge which health psychologists produce and encounter. We began with the question of whether research can be pluralist about knowledge, but at the same time non-relativist and promote

positive social action. We have tried to show that a pragmatist approach can have each of these three characteristics.

Firstly, pragmatism is deeply pluralist, recognising the validity of a variety of interests, perspectives, and forms of knowledge. Being anti-essentialist and anti-foundationalist, pragmatists are suspicious of any effort to privilege a single point of view. As we have argued, RCTs provide crucial information about the relative efficacy of specific interventions. This value in no way undermines the position that ethnographic case studies provide rich understandings of the social dynamics of a community health intervention, or that action research develops sophisticated practical knowledge of social change processes. The pragmatist position is that these methods are not in competition with each other, because each serves a different purpose.

Secondly, pragmatism's pluralism does not result in epistemological or moral relativism. Viewing knowledge as a tool that brings us into a more or less satisfactory relation with the world, knowledge can be evaluated for whether it works for us in relation to a particular goal or interest. Human interests, from a realist point of view, are considered to taint knowledge, making it somehow less true. From a pragmatist point of view, human interests are not the enemy of productive inquiry but the key to making our inquiry productive and useful, providing the criteria against which knowledge can be judged. Making moral choices among these interests, is a social and political activity, which should include critical assessment of the interests served.

Thirdly, pragmatism is a thoroughly action-focused perspective. Believing that the grounding for our knowledge is in concrete human activity, pragmatists do not accept solely intellectual arguments about concepts dissociated from their practical base. If the ideas are worth having and worth discussing, pragmatists argue, they must make a concrete difference for action (Peirce, 1878). The most stringent test of ideas is whether they work in practice, and so pragmatist health research would prioritise the creation and evaluation of workable and useful intervention programmes.

These three characteristics demonstrate the distinctiveness of the pragmatist perspective for health research. The major contribution of pragmatism is to bring some clarity to debates over method, by suggesting that methods, and knowledge, should be judged, not absolutely according to a 'hierarchy of evidence', but according to how well they serve specific interests. This brings the user of research – whether academic, health professional, activist or service user – to the fore in the evaluation of knowledge. Knowledge is to be evaluated according to whether it has useful consequences for the user's desired action. The criterion of usefulness is then tempered by the critical analysis of which interests are being served by that action.

References

Alcoholics Anonymous. (2007). The big book online. (4th edition). Available: http://www.aa.org/bigbookonline [Accessed 7 Dec 2007].

Baert, P. (2003). Pragmatism, realism and hermeneutics. *Foundations of Science, 8*(1), 89-106.

Baert, P. (2004). Pragmatism as a philosophy of the social sciences. *European Journal of Social Theory, 7*(3), 355-369.

Biesta, G. (2007). Why “what works” won't work: Evidence-based practice and the democratic deficit in educational research. *Educational Theory*, *57*(1), 1-22.

Camic, P.M., Rhodes, J.E. & Yardley, L. (2003a). *Qualitative methods in psychology: Expanding perspectives in methodology.* Washington, DC: American Psychological Association.

Camic, P.M., Rhodes, J.E. & Yardley, L. (2003b). Naming the stars: Integrating qualitative methods into psychological research. In P.M. Camic, J.E. Rhodes & L. Yardley (Eds) *Qualitative Methods in Psychology: Expanding perspectives in methodology.* (pp.3-16) Washington, DC: American Psychological Association.

Campbell, C. (2003). *'Letting them die': Why HIV/AIDS intervention programmes fail*. Oxford: James Currey.

Campbell, C. (2004a). Health psychology and community action. In M. Murray (Ed.), *Critical health psychology*. (pp. 203-221) Basingstoke: Palgrave Macmillan.

Campbell, C. (2004b). Creating environments that support peer education: experiences from HIV/AIDS prevention in South Africa. *Health Education, 104*(4), 197-200.

Clark, A. M., MacIntyre, P. D. & Cruickshank, J. (2007). A critical realist approach to understanding and evaluating heart health programmes. *Health, 11*(4), 513-539.

Cornish, F. & Ghosh, R. (2007). The necessary contradictions of 'community-led' health promotion: A case study of HIV prevention in an Indian red light district. *Social Science & Medicine*, 64(2), 496-507.

Crossley, M. L. (2000a). *Rethinking health psychology*. Maidenhead: Open University Press.

Crossley, M. L. (2000b). *Introducing narrative psychology: Self, trauma, and the construction of meaning*. Maidenhead: Open University Press.

Dobrow, M. J., Goel, V., & Upshur, R.E.G. (2004). Evidence-based health policy: context and utilisation. *Social Science & Medicine*, *58*(1), 207-217.

Evans, D. (2003). Hierarchy of evidence: A framework for ranking evidence evaluating health care interventions. *Journal of Clinical Nursing, 12*, 77-84.

Feyerabend, P. K. (1993). *Against method*. London: Verso.

Flyvbjerg, B. (2001). *Making social science matter: Why social inquiry fails and how it can succeed again*. Cambridge: Cambridge University Press.

Foster, J. (2007). *Journeys through mental illness: Client experiences and understandings of mental distress.* Basingstoke: Palgrave Macmillan.

Foucault, M. (1967). *Madness and civilization: A history of insanity in the age of reason*. London: Tavistock.

Fox, N. & Ward, K. (2006). Health identities: from expert patient to resisting consumer. *Health*, *10*(4), 461-479.

Freire, P. (1970). *Pedagogy of the oppressed*. London: Penguin.

Fryer, D. & Fagan, R. (2003). Toward a critical community psychological perspective on unemployment and mental health research. *American Journal of Community Psychology*, 32(1), 89-96.

Gaskell, G. (2004). Science policy and society: the British debate over GM agriculture. *Current Opinion in Biotechnology*, *15*(3), 241-245.

Gillespie, A. (2006). Descartes' demon: A dialogical analysis of Meditations on First Philosophy. *Theory & Psychology*, *16*(6), 761-781.

Glaser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Habermas, J. (1989). *The structural transformation of the public sphere*. Cambridge: Polity Press.

Harris, R. P., Helfand, M., Woolf, S. H., Lohr, K. N., Mulrow, C. D., Teutsch, S. M., *et al*. (2001). Current methods of the US Preventive Services Task Force: A review of the process. *American Journal of Preventive Medicine*, *20*(3S1), 21-35.

Hepworth, J. (2006). The emergence of critical health psychology: Can it contribute to promoting public health? *Journal of Health Psychology, 11*(3), 331-341.

Hester, D. M. (2003). Is pragmatism well-suited to bioethics? *The Journal of Medicine and Philosophy*, *28*(5-6), 545-561.

James, W. (1977) *A pluralistic universe.* Cambridge, MA: Harvard University Press (Originally published, 1909).

Kloppenberg, J. T. (1996). Pragmatism: An old name for some new ways of thinking? *The Journal of American History*, *83*(1), 100-138.

Krause, M. (2003). The transformation of social representations of chronic disease in a self-help group. *Journal of Health Psychology*, *8*(5), 599-615.

Laub, C., Somera, D. M., Gowen, L. K., & Diaz, R. M. (1999). Targeting "risky" gender ideologies: Constructing a community-driven, theory-based HIV prevention intervention for youth. *Health Education & Behavior*, *26*(2), 185-199.

Lyles, C. M., Kay, L. S., Crepaz, N., Herbst, J. H., Passin, W. F., Kim, A. S., *et al*. (2007). Best-evidence interventions: Findings from a systematic review of HIV behavioral interventions for US populations at high risk, 2000-2004. *American Journal of Public Health*, *97*(1), 133-143.

Lyotard, J.-F. (1984). *The postmodern condition: A report on knowledge*. Manchester: Manchester University Press.

MacPhail, C. & Campbell, C. (1999). Evaluating HIV/STD interventions in developing countries: do current indicators do justice to advances in intervention approaches? *South African Journal of Psychology, 29*(4), 149-165.

Makela, K., Arminen, I., Bloomfield, K., Eisenbach-Stangl, I., Bergmark, K. H., Kurube, N. *et al.* (1996). *Alcoholics Anonymous as a mutual-help movement*. Wisconsin: University of Wisconsin Press.

Marks, D. F. (2002). Freedom, responsibility and power: Contrasting approaches to health psychology. *Journal of Health Psychology, 7*(1), 5.

Miller, H. T. (2004). Why old pragmatism needs an upgrade. *Administration & Society*, *36*(2), 243-249.

Moreira, T. (2007). Entangled evidence: knowledge making in systematic reviews in healthcare. *Sociology of Health & Illness, 29*(2), 180-197.

Murray, M. & Campbell, C. (2003). Living in a material world: Reflecting on some assumptions of health psychology. *Journal of Health Psychology*, 8(2), 231-236.

Nafstad, H., Blakar, R., Carlquist, E., Phelps, J., & Rand-Hendriksen, K. (2007). Ideology and power: The influence of current neo-liberalism in society. *Journal of Community & Applied Social Psychology*, *17*(4), 313-327.

Peirce, C. S. (1878). How to make our ideas clear. *Popular Science Monthly*, *12,* 286-302.

Pollock, A. (2004). *NHS Plc: The privatisation of our health care*. London: Verso.

Posner, R. A. (2003). *Law, pragmatism, and democracy*. Harvard: Harvard University Press.

Prilleltensky, I. (2003). Critical health psychology needs psychopolitical validity. *Health Psychology Update*, *12*(3), 2-11.

Prior, L. (2003). Belief, knowledge and expertise: the emergence of the lay expert in medical sociology. *Sociology of Health and Illness, 25*, 41-57.

Ratner, C. (2006). Epistemological, social, and political conundrums in social constructionism. *Forum: Qualitative Social Research*, *7*,(1). Retrieved from http://www.qualitative-research.net/fqs-texte/1-06/06-1-4-e.htm

Rorty, R. (1981). *Philosophy and the mirror of nature*. Princeton: Princeton University Press.

Rorty, R. (1998). *Truth and progress*. Cambridge: Cambridge University Press.

Rorty, R. (1999). *Philosophy and social hope*. London: Penguin.

Shields, P. M. (2003). The community of inquiry: Classical pragmatism and public administration. *Administration & Society*, *35*(5), 510-538.

Sykes, C. M., Willig, C., & Marks, D. F. (2004). Discourses in the European Commission's 1996-2000 Health Promotion Programme. *Journal of Health Psychology, 9*(1), 131-141.

Van de Ven, P. & Aggleton, P. (1999). What constitutes evidence in HIV/AIDS education? *Health Education Research, 14*(4), 461-471.

Wilkinson, R. G. (1996). *Unhealthy societies: The afflictions of inequality*. London: Routledge.

Wilkinson, S. and Kitzinger, C. (1994). *Women and health: Feminist perspectives*. London: Taylor & Francis.

Willig, C. (1999) *Applied Discourse Analysis.* Buckingham: Open University Press.

Yardley, L. & Murray, M. (2003). Qualitative analysis of talk and text: Discourse and narrative analysis. In Marks, D.F. & Yardley, L. (Eds). *Research Methods for Clinical and Health Psychology* (pp. 90-101). London: Sage.