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Pragma-Dialectics and Health Communication: Arguing for behavioural change in advisory health brochures

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ABSTRACT: In this paper, it is argued that a pragma-dialectical perspective on advisory health brochures can complement current research in the medical domain and vice versa. Advisory health brochures are characterized as a particular communicative activity type to show how this context influences the argumentative process. It is argued that the quality of argumentation in health communication needs more attention. Insights from behavioural theory and persuasion research may help to detect possibly fallacious manoeuvres.

KEYWORDS: behavioural change, communicative activity type, health brochures, health communication, pragma-dialectics, strategic manoeuvring.

1. INTRODUCTION

Institutions like governments and non-profit organisations publish advisory brochures to encourage behaviour that is beneficial for people's (mental or physical) health, such as healthy eating habits. Just as advertising and political discourse, this type of discourse is meant to make the addressee undertake a particular action or adopt certain behaviour. Unlike commercial and political institutions, health institutions are typically meant to serve the public good, and the advice spread by means of brochures can thus be expected to primarily benefit the reader. However, even health institutions have to take financial and political interests into account that might conflict with their primary aim. On top of that, although health brochures are an appropriate means to reach a lot of people, they are supposed to appeal to an anonymous, heterogeneous audience and these readers may be sceptical towards (part of) the advice or might even hold opposing views.

Anticipating such doubts and criticism, institutions offer arguments to justify their advice in health brochures, thereby engaging in an argumentative discussion. In the integrated pragma-dialectical theory of argumentation it is assumed arguers simultaneously pursue rhetorical and dialectical objectives (van Eemeren and Houtlosser, 2002, 2005). Institutions try to convince as many readers as possible to adopt the healthy behaviour, but they are also assumed to respect certain norms of reasonableness, so that the possible disagreement between the institution and the reader about the advice is

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resolved on the merits. Van Eemeren and Houtlosser (2002, 2005) have called the efforts of arguers to balance dialectical and rhetorical requirements *strategic manoeuvring*.

In health communication, most research is concerned with the persuasive effects of (the design of) messages, and not so much with the quality of the argumentation. In this paper, I would like to argue that the study of health communication could benefit from the normative perspective as provided by the extended pragma-dialectical theory as this theory provides a comprehensive approach to both the analysis and evaluation of argumentative discourse. In order to find out how argumentative practices embedded in the domain are affected by the particular contextual characteristics, these practices are considered as *communicative activity types*. It is argued that such characterization, together with the ideal model of a critical discussion, helps to detect problematic discussion moves. At the same time, insights from behaviour theories and persuasion research can shed more light on the strategic choices arguers make to bring about behavioural change.

In this paper, I will first give a characterization of advisory health brochures as a particular communicative activity type in the medical domain. Then I will discuss how communicative practices aimed at behavioural change fit into the pragma-dialectical framework. After that, I will discuss the need for a normative perspective on the argumentation presented in advisory health brochures.

2. ADVISORY HEALTH BROCHURES AS COMMUNICATIVE ACTIVITY TYPE

In the medical domain, communication essentially concerns the exchange of information and viewpoints on how to deal with health-related issues in order to improve or maintain the health of a population. Since the medical field attends to all aspects of both people's physical and mental wellbeing, the scope of medical communication is very broad and the parties involved are a wide variety of institutions, non-profit organisations, commercial players and individual patients. Especially governments play an important part in promoting public health, as they have the power to install laws and taxes, to enact laws and to provide health care (Gostin and Javitt 2001). They have the responsibility to employ all the means they have to their disposal to diminish health risks and protect people's health and wellbeing (Childress et al. 2002). Within the medical domain, different communicative practices, such as the doctor's consult or the package leaflet, have developed to address health-related issues. Since many modern-day health risks can be avoided or diminished by making different lifestyle choices (see e.g. Buchanan 2008), a common (relatively cheap) way for institutions to advise a large amount of people is the distribution of health brochures.

Advisory brochures are meant to help (lay) people to make the necessary changes in their lives in order to minimize health risks by offering expert advice. At first sight, these texts may seem just informative, but information about, for example, the advantages of exercising or the disadvantages of being obese is not merely directed at adding to the knowledge of the reader about exercising or obesity. Instead, the brochure contains these facts to convince the reader that he should exercise and that he should not get overweight. Since some readers may be sceptical towards the content of the brochure and doubt the acceptability of (part of) the advice, such as its necessity or its effectiveness, the advising institution presupposes that the advice will not be accepted by the addressee at face value,

and therefore offers those pieces of information that might convince him. Since the text is a monologue directed at a reader who cannot explicitly contribute to the discussion, the pragma-dialectical theory speaks of an *implicit* discussion.

Van Eemeren and Grootendorst (1984, 1992) argue that a reasonable resolution of a difference of opinion can only be achieved when all contributions are in accordance with the code of conduct for critical discussion. According to the model of critical discussion, a discussion ideally goes through four stages in which the standpoint is critically tested. To nonetheless do justice to argumentative practice, van Eemeren and Houtlosser (2002, 2005) have integrated a rhetorical component into the pragma-dialectical framework. They argue that discussants will manoeuvre strategically to find a balance between their dialectical and rhetorical goals by taking the preferences of the audience into account, by making strategic choices from the topical potential and by employing the appropriate stylistic devices.

The context in which a discussion is embedded poses special constraints on the choices to manoeuvre strategically but also creates possibilities. In order to come to a better analysis and evaluation of argumentative discourse, van Eemeren (to be published) and van Eemeren and Houtlosser (2005) discern different *communicative activity types*[1] in the context of which certain strategic manoeuvres are possible and others are not.

In the medical domain, different *genres* or *clusters* of activity types can be distinguished. Advisory health brochures can be considered as a particular communicative activity type, pertaining to the genre of *consultation* in the medical domain. The concrete representations of these communicative activity types in reality are referred to as *speech events* (van Eemeren, to be published). For example, an American brochure with advice about eating fruit called '5 a day' is a particular speech event which represents the communicative activity type of the advisory health brochure. Communicative activity types can be distinguished based on the specific characteristics pertaining to the four stages the discussion runs through, i.e. confrontation stage, opening stage, argumentation stage, and concluding stage. For every activity type, one has to specify the initial situation, the procedural and material starting points, the argumentative means, and the outcome of the discussion (van Eemeren & Houtlosser 2005, 2006).

An advisory health brochure is a strongly institutionalized communicative activity type that differs from other forms of communication on some dialectically relevant points. The initial situation is that an authoritative institution has identified a health problem among (parts of) the population and consequently spreads advice on this topic on her own initiative. Given that every person decides for himself whether he wants to read the brochure or not, the advice will not reach all those it is meant for, and will also reach people for whom the advice is not relevant. The discussion concerns the acceptability of an advice. The advice can be just the same as a physician would give to a patient in a doctor's consult. In doctor-patient interaction, however, it is the patient, and not the expert, who presents a problem for which he needs the doctor's advice. Brochures do not lend themselves for addressing just any health problem, but only those which have been

[1] The same concept was referred to as *argumentative* activity type in van Eemeren and Houtlosser (2005). Since these activity types need not always be completely argumentative, but the communication in them may contain argumentative exchanges or elements, the term communicative activity type is more appropriate.

well researched, against which people can undertake action themselves, and which fit in the policy of the institution concerned are apt for health promotion.

The procedural starting points (the discussion rules and the distribution of roles) are also formalized. In many countries, special rules apply to the form and content of advisory brochures which affect the discussion. The institution usually practices guidelines concerning the format of the brochure, such as the length and the use of visual elements. Besides these internal rules, there may also be externally established rules for health promotion similar to those which apply to advertising, which explicitly codify what information may be used and how it may be presented. Health claims, for example, should be scientifically justified and may not be misleading or manipulating. Such rules partly coincide with the pragma-dialectical rules for critical discussion. The format of the brochure also determines the strict distribution of roles in the implicit discussion: the institution is the initiator and takes the role of protagonist of a standpoint about a health advice upon himself, while the reader is presumed to play the role of antagonist who cannot actively engage in the discussion. On this point, the argumentative practice significantly differs from the ideal model, as antagonists ideally are in the position to ask (critical) questions about the argumentation of the protagonist in order to put the standpoint to the test. Besides that, the fact that a brochure is a written text with limited space is crucial, since this restricts the amount of issues that can be treated.

The material starting points (a collection of propositions about facts and values that can be used in the argumentation) are only partly formalized. Only for official institutions it is, to some extent, certain to which values and facts they attach importance. For one, they unmistakably have a strong belief in the desirability of living a long, healthy life and a great trust in medical science. The readers, on the other hand, constitute a heterogeneous group of which each individual has his own starting points. One reader may share the starting point about the importance of good health, whereas the other may prefer the joy he gets from smoking or eating fatty foods over a long life. Obviously, this complicates the protagonist's task.

The argumentative means that are used by the protagonist are facts taken from scientific research about the effects of the advised or discouraged behaviour and about the (un)desirability of these effects. Another argumentative mean is statistical information about the probability that the predicted effects indeed occur. In the argumentation, the protagonist may also refer to values and value hierarchies of the intended audience. Instructions on how to start or keep on acting as advised may also be used. To cover the intention of the protagonist, the persuasive message may be disguised as information.

The outcome of the discussion remains implicit. Every reader determines whether the argumentation is convincing or not and whether he will adjust his behaviour. In the end, he might reach agreement with some of the readers but there is no way that this is communicated to the protagonist. In doctor-patient interaction, on the other hand, the outcome of the discussion is determined within the conversation and the doctor will also be able to retract or modify his standpoint when his starting points appear to deviate too much from those of the patient. The implicitness of the discussion thus puts great constraints on the possible moves in advisory health brochures.

3. ARGUING FOR BEHAVIORAL CHANGE

The question is how the pragma-dialectical ideas about the goals of argumentation can be reconciled with the goal of health messages to achieve behavioural change. Although the integrated pragma-dialectical theory considers, at least to some extent, the effect of argumentation, the theory is only concerned with externalizable verbal acts that are exchanged in a discussion. Pragma-dialectics is based on principles derived from Austin's (1962) and Searle's (1969) speech act theory, assuming that every utterance has a specific function and is therefore considered as a goal-oriented verbal act, or speech act. An utterance can be aimed, for example, at making the addressee perform an action, representing a state of affairs, or expressing an emotion.

Van Eemeren and Grootendorst (1984, p. 43) regard argumentation as a (complex) speech act which counts as an attempt to convince the listener of the acceptability of an expressed opinion by advancing a constellation of statements. Argumentation is therefore associated with the *interactional* act of convincing. The expressed opinion can be a factual statement but also an inciting or evaluative statement referring to particular behaviour, such as in "You should eat 5 portions of fruit per day" and "It is good to exercise every day." In case the argumentation was successful and the listener accepts the expressed opinion, the speaker has performed the interactional act of convincing (van Eemeren & Grootendorst 1992, p. 27). Just as by making a promise, by performing the act of acceptance a listener commits himself to the opinion and thus to having the intention of indeed performing the behaviour. The sincerity condition of the speech act of accepting in fact relates to the speaker's intention (Searle 1979, pp. 14-15).

Consequently, argumentation in health brochures should be understood as an attempt to convince the reader of the acceptability of a health advice by putting forward a constellation of statements. In accordance with theories of behavioural change (see e.g. O'Keefe (2002)), pragma-dialectical theory assumes that argumentation cannot directly make someone perform particular behaviour. A successful attempt may lead to an explicit act of accepting by the other party who thereby expresses the commitment or intention to carry out the advocated behaviour. The intention might, under the right conditions, lead to the consecutive consequence of actually performing the behaviour, but this need not be the case. It is important to notice here that pragma-dialectics, contrary to behaviour theories, is only concerned with externalized or externalizable verbal acts, such as arguing or accepting, and not with states of mind such as being convinced (van Eemeren & Grootendorst 1984, p. 69).

Nevertheless, there is some correspondence between the rationality behind speech act theory and behavioural models, in the sense that some of the correctness conditions of accepting an advice resemble the factors that are commonly understood as the determinants of intention, which leads to actual behavioural change. The three main determinants of intention are one's position towards performing the behaviour (attitude), what others think of performing the behaviour (the perceived norms), and one's perceived capability of performing the behaviour (self-efficacy) (see Fishbein and Cappella (2006); Ajzen & Fishbein (1980); Ajzen (1985)). From a speech act perspective, one of the conditions for acceptance is that the speaker believes that he is able to follow up the advice, which coincides with one's perceived self-efficacy. Another speech act condition is that the speaker believes that the advice is beneficial for him, a condition that

corresponds to the beliefs that form the basis for a positive attitude towards the advocated behaviour.

Theories of behaviour can be complementary to a pragma-dialectical approach to health brochures, as they might shed more light on the strategic choices that are made in this communicative activity. For example, institutions will probably try to address the beliefs of the target audience that need to be changed in order to achieve a change in attitude, perceived norms, and/or self-efficacy (Fishbein & Cappella 2006, pp. 58-59). The various ways in which institutions try to implement such theoretical assumptions in practice (see e.g. O'Keefe 2002), can be explained in pragma-dialectical terms. For example, O'Keefe (2002, p. 21) argues that when people already have positive attitudes towards the advocated behaviour, but still do not seem to act accordingly, the arguer could emphasize the relevance of people's existing attitudes towards their behavioural choices. From a pragma-dialectical perspective, referring to people's existing attitudes comes down to emphasising people's material starting points in the argumentation: the acceptability of a claim is then demonstrated by transferring the acceptability of the premises to the claim. In order to be successful in this, arguers should use acceptable premises, or, in other words, people's existing attitudes. It can also be the case that the problem is not attitudinal, but related to the addressee's perception of self-efficacy (O'Keefe 2007, p. 160). In that case, the arguer can try to convince the reader by addressing the (possible) counterargument that the other is not able to perform the advocated behaviour.

Such choices can be seen as aspects of strategic manoeuvring, namely choosing the appropriate move from the topical potential, adapting the move to the preferences (or existing beliefs) of the target audience and employing the most appealing stylistic means. However, whereas persuasion effect research and behavioural models are concerned with actual change in behaviour or intention, pragma-dialectical theory only focuses on the way in which arguers try to achieve this effect. Once an arguer has persuaded the other party, he has achieved his rhetorical objective, but that does not mean he also managed to really resolve the difference of opinion on the merits.

4. A NORMATIVE FRAMEWORK IN HEALTH COMMUNICATION

From a rhetorical perspective, the purpose of argumentation is to get the standpoint accepted by the other party. In practices such as advertising, this intention indeed seems to dominate. To protect the public, there are regulations in force all over the world for advertising which prohibit, for example, false or overstated health claims, leaving out side-effects and misleading presentation or word choice. Advertisers are thus expected to consider certain rules in their attempt to persuade the addressee, which are comparable to the pragma-dialectical discussion rules. They still try to be as rhetorically effective as possible, but they thereby run the risk of being criticized or being forced to adjust or revoke their message when they violate the rules.

In the medical domain, striving solely for persuasion is even more problematic as there is a disparity in knowledge and power between sender and receiver of the message. For a reasonable resolution, readers need to understand all relevant issues to be able to critically assess the justification of the standpoint and they also should be free to do so.

This is of special importance in the health domain, since health choices can have great impact on people's lives.

For some health professionals there are in fact rules laid down in law by means of the concept of *informed consent* that define what and how they should communicate to patients that seek their professional help. The obligation to offer all the information patients need to critically assess different treatment options also influences the argumentative situation in doctor-patient interactions (see Schulz & Rubinelli 2008). However, the law only applies to medical personnel and not to the general information and (justification for) advices coming from charities and governmental institutions. Due to the fact that health brochures are their to serve the public good, one would expect that they are in accordance with rules for a critical discussion, in the sense that they, for example, address possible counterarguments, and contain clear and truthful statements and reasonable arguments. But the particular characteristics of the communicative activity type as described in section 2 make the argumentative practice less than ideal.

For example, due to the anonymity of the antagonists it is impossible to verify whether certain starting points are shared and to address all possible counterarguments. In addition, when medical institutions besides their humanitarian aims also have to take financial or political interests into account, it will become much harder to reasonably justify that the advice is indeed beneficial for the individual reader. Because of the heterogeneity of the audience, institutions in fact have multiple rhetorical goals as they try to convince every single reader. In this attempt, they have to avoid coming across as overly paternalistic, while they also have to protect the interests of the population as a whole (see e.g. Childress et al. 2002; Bayer and Fairchild 2004; Buchanan 2008).

Results from studies in health communication can be instrumental in explaining what moves arguers may make to be rhetorically effective and what instances of strategic manoeuvring may become problematic. O'Keefe (2007) has pointed out that some strategic choices, such as framing, may not directly be fallacious, but in some way still not seem to be in accordance with the norms the sender is supposed to adhere to. Referring to the responsibility medical institutions have towards the public, O'Keefe raises the question whether it is normatively admissible to exploit those means to bring about persuasive effects. This is a very important question, especially in argumentative practices which are characterized by power and informational asymmetry between institution and reader. What is more, the institution has obligations to the individual reader *and* the population as a whole.

Theories and models of behaviour give some indications of what strategic choices may be geared too much towards rhetorical success. For one, institutions might exaggerate or understate the health risks associated with a particular behaviour in order to influence the reader's attitude. A second danger is that institutions address societal expectations or norm concerning the behaviour or appeal to the emotions of the reader. Choices like that may result in an *ad populum* or pathetic fallacies (van Eemeren and Grootendorst 1992, pp. 134, 166). The issue ultimately comes down to the question whether the end justifies the means: is it admissible to choose the most persuasive justification in a situation where people must make health choices, just because the institution believes it is in the people's interest?

A pragma-dialectical approach to health brochures can indicate what argumentative means institutions employ in pursuit of rhetorical success and to what

extent a reasonable resolution is still possible in this kind of discussion. Using the pragma-dialectical framework, possible fallacious moves can be related to the specific situation in the discussion stage within the particular activity. Starting from the characterization of advisory brochures as a particular communicative activity type, it can be shown that a move, for example, is problematic because it is a way to falsely introduce a proposition in the opening stage as a mutual starting point.

Whether health institutions should be allowed to persuade people to do what the institution thinks is in their best interest, is a moral or political issue. Seen from a pragma-dialectical perspective, institutions may be able to reasonably justify why the reader should adopt the advocated behaviour, but as soon as they intentionally disregard the discussion rules, they no longer intend to jointly resolve the (implicit) difference of opinion with the reader on the basis of rational justification and refutation. In that case, the strategic manoeuvring derails and no true resolution is possible.

4. CONCLUSION

Through health brochures institutions attempt to convince readers of the acceptability of health advice with the most effective argumentative means. At the same time, institutions are expected to adhere to certain norms of reasonableness to enable a resolution of the difference of opinion on the merits. To balance these goals, arguers resort to strategic manoeuvring. A characterisation of health brochures as a communicative activity type indicates what strategic choices arguers do, and do not have to their disposal and where they are likely to let their rhetorical intentions get the upper hand.

In health communication, it is of special importance that the public gets the opportunity to critically assess health claims and their justification, because of the unequal position of institutions and the public and the possibly far-reaching consequences of accepting or not accepting an advice. In this paper I have therefore argued that a pragma-dialectical approach might be fruitful to the analysis of health communication and vice versa.

Although the pragma-dialectical theory of argumentation has a different angle on health communication as it focuses only on the argumentative process and not on the outcome of that process, it can be complementary to current health communication research by providing analytic and normative tools. Behavioural theories and persuasion research, on the other hand, can help explain why institutions choose particular lines of defence and thus help detect those strategic manoeuvres that are likely to derail.

Link to commentary

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