FOUNDATIONS OF COMMUNICATION THEORY

HEALTH COMMUNICATION THEORY

EDITED BY
TERESA L. THOMPSON
AND PETER J. SCHULZ

WILEY Blackwell

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Foundations of Communication Theory

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To Steve and Connor….
Love, Teri/Mimi

To Magda and my sons Thomas E., Lukas P. and Markus J.
In gratitude, Peter

With warm thanks to Scott Poole
TT and PS

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PART I
Perspectives on the Field of Health Communication

1
The Basics of Health Communication Theory

Teresa L. Thompson and James D. Robinson

Health problems are prevalent all over the world, and communication processes play essential roles in addressing these health problems. From Ebola, MERS, Zika, and COVID-19 to vaping and the opioid epidemic, various health crises must be confronted across the world on a constant basis. The area of study that has come to be called "health communication" is crucial as practitioners and scholars attempt to alleviate and minimize a multitude of health problems and improve health care delivery. Effective and useful health communication is foundational as we attempt to control the spread of disease and health problems.

Do *message strategies* that encourage people to manage their diet to control diabetes also inspire them to look more closely at vaccination decisions? In other words, can we generalize what we learn about health communication regarding one health problem to other health issues? Does the study of patient-centered communication have implications for mental health as well as physical health and illness? Does message targeting or tailoring allow the effective adaptation of anti-vaping messages to different audiences? These and other questions are conceptual and theoretical concerns that underlie health promotion and a broader understanding of health communication processes. Through health communication research one may understand not only how communication operates in relation to a particular health issue, but how health

communication functions more broadly. Indeed, the ultimate hope is an increased understanding of communication processes across contexts and a healthier world.

As is evident in the title of this volume, the focus of this book is on the theories that we use to study health-related processes. Our goal is to help students, scholars, and practitioners more adequately examine health communication concerns by grounding their work in solid theory. We thus begin the volume by briefly defining health communication, health, health care delivery, and theory. We then talk about why theory is important in the study of health communication. We follow this with brief discussions of the traditions of health communication theory and generative tensions in health communication scholarship. This chapter concludes with a preview of the remainder of the book and a discussion of ethical concerns.

What is Health Communication?

It is frequently noted that the area of study that has become known as health communication began to emerge from research in the 1940s that looked at the persuasive impact of health information and promotion, although Salmon and Poorisat (2019) point to even earlier traditions from the field of public health. This work goes back to the development of germ theory and can be traced to the beginning of the twentieth century. Starting with newspapers and then moving to film, radio, and television, media campaigns about health issues began to appear. The emergence and refinement of social science research methods, including the development of Thurstone and Likert-type scales and sampling techniques à la George Gallup, was another central factor in the progress that was made during earlier decades of the twentieth century.

Salmon and Poorisat (p. 1) identify four key factors that influenced and characterized this growth:

1. the early use of mass communication for public health campaigns (1900–1910s);
2. the search for effects (1920–1930s);
3. the search for explanation from interdisciplinary perspectives (1940–1950s); and
4. the formal recognition of health communication as a distinct and valuable field of practice and research (1960s).

The reader will see these influences reflected in the theories and chapters that follow.

The Stanford Heart Disease Prevention Program, which began in 1971, was also an important development in the history of health communication. During the early 1970s scholars such as Barbara Korsch and her colleagues (e.g. Korsch and Negrete, 1972) conducted work that served as the foundation of research on physician–patient communication. This work, published in such prestigious outlets as *Scientific American*, created interest within the broader field of communication. Some of this work was labeled “medical communication.” Simultaneously, scholars building on the interactional view articulated in Watzlawick, Beavin, and Jackson’s (1967) *Pragmatics of Human Communication* and further developing the conceptualization of communication processes offered by Gregory Bateson (1972) focused on what was called “therapeutic communication.” These traditions came together beginning in the early-1970s to prompt the development of the new area of study called “health communication.” The inception of the Health Communication Division of the International

Communication Association in 1975 (following the founding of the Health Communication Interest Group in 1972) most clearly demarcated this new area of study. The movement within medicine, public health, and the social sciences from a biomedical approach to a biopsychosocial view was simultaneously occurring (see Ho and Sharf, Chapter 14 in this volume, for more discussion of this).

The area of health communication did not take long to develop. Books on the topic, most notably Kreps and Thornton's (1982) *Health Communication: Theory and Practice*, began to emerge in the early 1980s. By 1986, enough work was being conducted in the area that the publisher Lawrence Erlbaum Associates expressed interest in a journal on health communication. The first author of the present chapter, who is also the editor of the journal *Health Communication*, began soliciting submissions in 1987, and the first issue of the journal came out in January of 1989. The journal originally published four issues a year, but at the time of the writing of this chapter is publishing 14 lengthy issues a year. During 2019, the journal processed 776 submissions. Two hundred and nine issues of the journal have now been published. *Health Communication* was shortly followed by *The Journal of Health Communication: International Perspectives*, *Patient Education and Counseling*, *Journal of Communication in Healthcare*, *Communication and Medicine*, and several other outlets. The *Journal of Health Communication* began publishing in 1996. The first edition of the *Handbook of Health Communication* (chapters of which were translated into Korean) was published in 2003, and the second edition, *The Routledge Handbook of Health Communication* was published in 2011. The third edition of the handbook is in press at the time of the writing and will be published in 2021. *The Sage Encyclopedia of Health Communication*

came out in 2014. All of these publications are evidence of the rapid growth of this area of study.

International interest in health communication has also increased notably over the last three decades. This is reflected in the subtitle of the *Journal of Health Communication: International Perspectives*, but is really reflected in the work published in all the health communication outlets. The journals all receive and publish submissions from a variety of countries. As continents, Europe, Oceania (Australia and New Zealand), and Asia are particularly active in health communication scholarship, as is North America. Within Europe, scholars in the Netherlands, Switzerland, and the UK are highly involved in health communication research. The Asian countries of Korea, China, Taiwan, and Singapore are also replete with active health communication researchers. In North America, health communication research is conducted in both the US and Canada.

The initial issue of *Health Communication* included many invited pieces by such important scholars as Barbara Korsch, Gary Kreps, David Smith, and Jon Nussbaum. These pieces attempted to set the agenda for the field – and they did, continuing to be cited during subsequent decades. Several articles in the 100th issue of the journal referred back to these articles and identified the progress that had been made over the last 100 issues. Much advancement was, indeed, apparent. Many of the directions suggested by these scholars have now been actualized.

Early submissions to and publications in *Health Communication* tended to be atheoretical and offered relatively simplistic views on communicative processes, although not as simplistic as those that are still apparent in the research conducted today by submitters without a background in the social sciences. The quality and focus of

most of the work that is now submitted to the journal has changed substantially in the 30-some years in which the journal has been publishing, and work is rarely accepted for publication without a guiding theoretical foundation.

As is the case with any area of study or phenomenon, varying definitions of health communication have been offered. The process of communication focuses on simultaneous, transactional message co-creation of meaning through interaction. Health communication focuses on such processes as they relate to and impact health and health care delivery. The primary areas of study that are the foci of health communication work include provider–patient communication, health campaigns and other types of health promotion, health information in the media, eHealth and mHealth, health risk communication, communicative processes within health organizations, and everyday health communication (see Kreps 2020, for more detailed discussion of many of these areas). Everyday health communication focuses on communication *about* health and as it *impacts* health among family members and friends, as opposed to that communication which takes place with formal health care providers and through mediated channels of communication (Cline 2011; Head and Bute 2018).

What are Health and Health Care Delivery?

Although most of us probably have an ordinary conception of health as a state of being disease-free, more precise conceptualizations of it have been offered. The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (The World Health

Organization 2020, n.p.). Please note the focus on mental and social issues as well as physical health.

Building on this, the US National Institutes of Health (NIH) defines health care delivery as “The concept concerned with all aspects of providing and distributing health services to a patient population” (NIH 2020, n.p.). Although this definition appears to focus on formal health care delivery, health communication scholarship goes well beyond this traditional emphasis. The best health communication work is that which is grounded in theory.

What is Theory? What is Health Communication Theory?

The term “theory” is used rather loosely in ordinary conversation (“I have a theory about why my brother is so messed up”) but has a more precise meaning in scholarship. Once again, many different definitions are offered of theory. Put fairly simply, a theory is an attempt to explain a phenomenon or set of phenomena in a testable manner. It provides guidance for research and can serve as a lens or a map. It is a supposition that is based on past research. This makes it an educated guess. It should not be tautological or based on circular reasoning. The theory should be independent of the phenomenon to be explained. Theories make predictions which are then testable.

Theory plays a different role in qualitative/interpretive research than it does in positivist/quantitative research. Whereas good quantitative research is typically grounded in and tests theory, qualitative research is more likely to generate theory. The goal of interpretive work is to reform society and generate understanding more than to test predictions and hypotheses. Jill Yamasaki (Chapter 3 in this

volume) articulates this difference in more detail and makes clearer the role of theory in interpretive work.

Babrow and Mattson (2011) offered a useful definition of health communication theory in the 2nd edition of the *Routledge Handbook of Health Communication*. They define health communication theory "as consciously elaborated, justified, and uncertain understanding developed for the purpose of influencing practice related to health and illness" (p. 19). This will be our working definition of health communication theory in this volume.

Why Do We Need Health Communication Theory?

As is the case with any area of scholarly study, health communication work that is guided by a theoretical framework is stronger than work that is atheoretical. Some work that falls within the general category of health communication is problem-focused but not theoretically framed. Work that is based in theory is more systematic than is work that is problem-oriented but atheoretical. Work that is grounded in theory is generalizable beyond the particular context or health condition that was the focus of the original study. Good theories are not content- or health-problem-specific. They apply to broader communicative processes, not just to a particular health problem or in a particular setting. Good theory is, most importantly, practical and applicable to social concerns.

If a study on diabetes management is grounded in a perspective such as the theory of reasoned action, findings from that study will provide insights that scholars may apply to other health problems and contexts. Although generalizability is partially based on sampling, design issues, and ecological validity concerns, it is also based on

theoretical framing. Through the theoretical grounding of a study the broader base of knowledge is extended. This is the goal of scholarship. This is how a body of knowledge is built.

One of the more interesting examples of theory being extended into new areas of study is cybersecurity. If imitation is the sincerest form of flattery, theories of health and health communication should at least blush occasionally. Several theories discussed within this volume have gained theoretical traction in research on computer security.

Scholars studying how to motivate end users to engage in safe computer practices use the health belief model (Rosenstock 1974), the protection motivation theory (Rogers 1975), and the transtheoretical model (Prochaska and DiClemente 1983) to guide their research.

For example, Ng et al. (2009) found that perceptions of susceptibility, benefits, and feelings of self-efficacy were the best predictors of opening email attachments. The analogue of "don't click on links or open unexpected email attachments" in the realm of health is "maintain social distance and wash your hands." Viruses move through contact and malware moves through virtual contact or email.

Recently researchers from Carnegie Mellon (Faklaris, Dabbish, and Hong 2018) recognized the value of the transtheoretical model for designing security interventions. Their recommendations acknowledge that, just like the public in a general health information campaign, end users are not equally accepting or ready for making changes to their behavior. By targeting messages based on users' current readiness or stage of change, cybersecurity professionals may increase the effectiveness of their campaigns and training materials. Also important,

developing targeted messages may help reduce the feelings of cyber-fatigue that are now recognized as the bane of security training efforts.

Training programs for avoiding phishing attacks and ransomware attacks require different lists of rules. It is no wonder that end users receiving information not targeted to their readiness produce fatalistic attitudes about cybersecurity training.

Fortunately, health communication theory has come to the rescue here, too. Recent research by Zhang and Borden (2019) employed the extended parallel processing model (Witte 1994) and found fear and anxiety mediated end-user behavior. Specifically, negative emotions were shown to influence the impact of threat on end-user intentions to comply and seek additional information. Efforts to motivate end-user cybersecurity behavior need to consider the role self-efficacy plays in the process. It remains to be seen how effective these theories will be, but it is clear scholars from other disciplines are looking to health and health communication for theoretical models. The next section of this chapter focuses on the different types of theories. The breadth and depth of these theoretical traditions have certainly helped us grow the discipline.

Traditions of Health Communication Theory

Much has been written about communication theory as an area of study over the last several decades. Perhaps the most frequently cited and well-known work on communication theory was published by Robert Craig (1999) in the journal *Communication Theory*. Among the many important points made by Craig is an insightful discussion of the multiple disciplines from which

communication theory has developed. These varying disciplinary roots have led to rather different conceptualizations of the nature of theory and its application in the broad field of communication. Craig notes that acknowledging these differing roots is more fruitful than arguing about the validity of varying theoretical approaches. Craig identifies seven traditions of communication theory. His discussion has become foundational to our understanding of theory in the field of communication.

Building on this work, Babrow and Mattson (2003, 2011) identify how these traditions apply to health communication scholarship. They trace the following lines of research and knowledge in this discussion: (i) rhetorical ("the practical art of persuasive discourse", Babrow and Mattson 2011, p. 25); (ii) semiotic ("intersubjective mediation by signs and sign systems", p. 26); (iii) phenomenological ("communication as dialogue or experience of otherness", p. 26); (iv) cybernetic ("information processing by which systems are able to function", p. 27); (v) sociopsychological (a focus on behavior expressing psychological systems, states, and traits producing a variety of effects); (vi) sociocultural (symbolic processes producing and reproducing sociocultural patterns that are shared within a group); and (vii) critical traditions (which focus on "material practices and hegemonic ideologies that distort communication" p. 29). More of the theories to be discussed in the remainder of this volume focus upon sociopsychological and sociocultural traditions than on the other traditions (for exceptions see Ho and Sharf, Chapter 14 in this volume). Understanding the conceptualization of communication and theory on which a particular theory is based is important in order to adequately assess the value of that theory and research.

Generative Tensions in Health Communication

Understanding theory in health communication is also directly related to comprehension of the “generative tensions” underlying the study of health communication (Babrow and Mattson 2011, p. 19). One of these tensions focuses upon the interplay of the body and communication that is inherent in the biopsychosocial turn that has been key to changes in views of medicine in the last few decades. The guiding principles after the turn are: Disease shapes communication. Communication shapes disease and other aspects of health. Social and cultural factors influence all aspects of health communication. How disease is defined and the manner in which we communicate about it determine how it is treated.

A second generative tension is related to this – the opposition between science and humanism. Contrasts between the potentialities of science vs the actualization of being human epitomize this. Babrow and Mattson (2011) exemplify this tension through a discussion of death and dying. The contemporary fear of mortality is but one factor that captures and typifies this tension.

The strain between idiosyncrasy and communality characterizes the third generative tension that they identify. The contrast between ontological and holistic views of medicine makes this apparent. Finally, the experience of uncertainty and values are central to the fourth generative tension described by Babrow and Mattson (2011). This tension will be most apparent in the chapter written by Babrow, Matthias, Parsloe, and Stone (Chapter 13 in this volume), which focuses on uncertainty management theories.