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Joseph Petraglia[a]
[a] Global Health Communication,

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The Importance of Being Authentic: Persuasion, Narration, and Dialogue in Health Communication and Education

Joseph Petraglia
Global Health Communication

A topic gaining attention in the field of education has been that of "authenticity"—the creation of learning environments that provide learners with richer and more realistic contexts in which to apply knowledge and practice skills. The subject of authenticity has yet to attract much attention in the field of public health and specifically in health communication and education, although these fields have long experience with the problem of getting audiences to translate knowledge into action. This article reviews the rationale for an interest in authenticity as it relates to health communication and education and notes that "authenticity" does not inhere in information but is an appraisal made by a member of the public who is persuaded to view the information as especially relevant to his or her health behavior and consonant with his or her prior experiences. This article argues that a public health communicator or educator can encourage such appraisals by using narrative formats that provide rich contextualization. But contextualizing behavior change information in the form of stories is not enough; there is a dialogic dimension to persuasion that aids in the process of authentication. Creating opportunities for dialogue between behavior change narratives and their audiences has its own challenges, but nonetheless deserves to be a priority in public health.

On entering the field of health communication and education from the academic study of rhetoric, I quickly stumbled across the term *KAP-gap*. This gap, separating health knowledge and attitudes on one side and actual health practices on the other, describes what all educators have long known: it may be easy to learn facts, but without the ability and willingness to apply information to the contexts in which the information is relevant, knowledge is wasted. Health communication and education professionals also know that many public health interventions designed to bridge the KAP-gap are unsuccessful. Part of the problem may be that health information circulates so widely but so impersonally, that it blends into the scenery. For many public health target audiences, information and messages about illness and disease and exhortations to change risky behaviors can easily become white noise—a droning buzz in the background that only occasionally reaches consciousness. Even when information is attended to and committed to memory, it is in danger of becoming inert (Whitehead, 1929)—fossilized in memory with little connection to application. What this information lacks is what some in education circles call "authenticity"—not just perceived relevance but a felt relevance that pulls information out of the background and to the fore. Authenticity enables individuals to understand, emotionally as well as cognitively, how information can relate to their everyday existence.

The challenge of getting people to apply knowledge to their own lives is not unique to public health, of course. In fact, the issue of what makes information authentic has quietly motivated educational reforms and debates for most of the last century (Petraglia, 1998). As a construct whose definition remains unsettled (Barab, Squire, & Dueber, 2000; Herrington, Oliver, & Reeves, 2003; Lebow & Wager, 1994; Shaffer & Resnick, 1999; Stoner, 2006; Zuga, 1994), the messy literature on "authentic learning" slops over into a number of topics more commonly considered in the health communication literature (e.g., narrative, persuasion, dialogue), but these topics are examined in isolation from one another and almost exclusively from the vantage point of clinical and mental, rather than public, health.

Correspondence should be addressed to Joseph Petraglia, Global Health Communication, 418 Claire Dr., Atlanta, GA 30307. E-mail: joseph@ghcomm.org

The objective in this article, then, is both to discuss authenticity as a desired educational and communication outcome and to suggest how it might be attained in public health practice. In doing so, my argument follows a somewhat crab-like progression from constructivism as the theoretical perspective that gives rise to an interest in "authenticity," to persuasion as the means of convincing individuals that information is authentic, to narrative as a potentially rich format for persuasion, and finally, to dialogue, which, I will argue, needs to accompany narrative-based interventions (i.e., those that use stories to contextualize health issues) if they are to engage the publics we wish to reach.

In addition to suggesting how these concepts can be shown to converge on the subject of authenticity, I wish to argue that there are methodological and disciplinary constraints that seem to keep a cohesive notion of authenticity from gaining ground in both public health scholarship and practice. Because public health communication and education practitioners frequently need to work within the constraints of bio-medicine as a practical matter, constructivist notions like persuasion, narrative, dialogue (and, thus, authenticity) are difficult to make operational. Nevertheless, I conclude by asking readers to consider a couple of public health programs that I believe have the implicit aim of authenticating health information at their core.

THE RISE OF "AUTHENTICITY"

Throughout recorded history, societies have been content to view education as the studiously artificial training of an elite destined to manage a society (Clark, 1971). At the heart of this training lay rigid dichotomies separating teacher from student and learner from that-which-is-to-be-learned. This so-called "instructivist" model of learning was not intended to nurture creativity and critical thinking but to produce an educated citizenry who could demonstrate rote mastery over texts and formulae. Instructivism was predicated on the assumptions that there is an objective body of information that can be accurately understood, that instructors are expert in this information themselves, and that the goal of education is to faithfully reproduce knowledge of this information in novice learners. Hardly an artifact of bygone eras, instructivism remains the dominant form of education in most parts of the world today.

A number of philosophers, psychologists, and educational reformers in the late 19th and early 20th centuries began to challenge the instructivist tradition, however. The epitome of such a reformer, perhaps, was the pragmatist John Dewey, who argued that education should be less artificial and abstract and, instead, draw more from learners' experience. From Dewey's perspective, much of what goes on in formal learning environments is poor preparation for how students really apply knowledge in genuine contexts. For education to serve the needs of both the learner and society, he wrote, it "must be based upon experience—which is always the actual life-experience of some individual" (1938, p. 89). Genuine education is that which brings together not only the material and social conditions that shape one's world but one's beliefs about the world as well. Instead of imposing knowledge and methods, educative environments should permit learners to generate their own working theories of how knowledge operates in the world around them. Whereas traditional education set out artificial problems requiring formulaic solutions and authoritative teachers, Dewey saw the educator's role as one that helped put the student's real-world experiences into fruitful dialogue. In this way, the complexity and context-sensitive nature of problems could be appreciated and real, generative learning transpire.

The view Dewey and others were articulating was an early expression of constructivism: the recognition that learners do not objectively and faithfully acquire knowledge of the external world, but actively construct an understanding of that world based on prior experiences, personal knowledge and attitudes, and culturally sanctioned interpretative practices. Constructivism poses serious methodological challenges for the educational researcher, however. For most of psychology's short disciplinary history prior to Dewey, experimentalism necessitated a model of learning that clearly delimited a start and an end of the learning "episode"; it required that the learning be isolated from both pre-existing and collateral knowledge, and certainly took no account of the social dimension of real-world learning. Studies focused on types of episodic learning that lent themselves to replication without regard to learners' other experiences and background. Experimentation within the behaviorist framework in the United States (and, later, the "information processing paradigm" in early cognitive psychology that dominated the field for decades) neatly fed into instructivism and ensured that formula-driven education was the norm in most American learning theory. But Dewey's pragmatism, alongside growing awareness of European constructivist theory, as exemplified in the work of Jean Piaget and Lev Vygotsky, produced an increasingly coherent constructivist "metatheory" that has real-worldliness and authenticity at its heart.

In contemporary constructivist thought—widely accepted in theory if not always in practice—cognition is not an abstract, purely symbolic manipulation of data but a process embedded in our everyday interactions with the world, interactions that are always mediated by language or symbols. Language is the means by which we "share" and "distribute" cognition (Hutchins, 1995; Lave, 1991; Nardi, 1996; Perkins, 1987; Resnick, 1991). This perspective on learning takes the focus off the thinker in isolation and asks that we look to everyday activity as a source of information; we think in conjunction with our perceptions of the world around us. Other things and other people not only inform

our cognition but extend it. In a manner of speaking, our real worlds are not so much a resource that we draw on but a larger cognitive network that demands synthesis and interpretation rather than procedural understanding. As Gordon (1998, p. 391) argues, "Authentic learning situations simultaneously involve one's knowledge, skills, and attitudes." Dunn (1994) extends this and concludes that providing rich contextualization and connections with learners' prior experience is the only means to make learning relevant; "In a word, [contexts for learning] need to be authentic" (p. 84).

Most learners, of course, "realize that complex, multidimensional problems are much more endemic to real-world activity" than problems presented to them by educators in formal settings (Clark, 1995, p. 259). Therefore, constructivists argue that real-world relevance and clear application is needed to combat perceptions of inauthenticity. Effective education

> is concerned with depth of learning rather than the breadth of information sucked in and then spewed out; where memorization is misdiagnosed as being well-informed. Authentic learning environments provide . . . rich experiences and opportunities to construct knowledge in context, and in ways that make sense to their existing knowledge which is based on prior experiences (Barab et al, 2000, p. 39)

For this reason Barab et al. (2000) talk about authenticity as an "emergent" process that ". . . lies in the learner-perceived relations between the practices they are carrying out and the use value of these practices" (p. 39).

Several approaches to contextualization have appeared in educational thought. Problem-based learning is one such approach in which Dewey's theory of learning-by-doing is made operational (see Schmidt, 1993). The subfield of educational technology extends problem-based learning with variations such as anchored instruction (CTGV, 1990) and goal-based scenarios (Schank, 1992). Problem-based learning and its anchored instruction and goal-based scenario variations all subscribe to what has come to be known as the "authenticity principle" (Collins, 1994, p. 30). According to this principle,

> Knowledge, skills, and attitudes should be embedded in tasks and settings that reflect the uses of these competencies in the world . . . the authenticity of the learning environment ensures that the knowledge gained will be readily available in the kinds of situations they will face in their [users'] work. (p. 30)

In short, contemporary learning theory suggests that learners' perceptions of authenticity are critical because learning is embedded in our everyday experience of the world rather than in the world of formal information dissemination such as practiced in most schools and reflected in most health campaigns. Information and problems perceived to be authentic entail social contextualization and ego involvement, which influence all subsequent mental processing. This in turn prompts various kinds of engagements, arousals, and motivations, which, as research into affect and cognition suggests, result in an array of attributions, inferences, judgments, and schema-instantiations (Forgas & Bower, 1987; Oately, 1996; Tan & Frijda, 1999; Wyer & Srull, 1986). Thus, authenticity is not exclusively—or even predominantly—about the objective accuracy of information as much as it is about one's attitude toward information. Of course, the interplay of content and one's stance toward that content is impossible to tease apart, but the point is that the legitimization of information as authentic is not a matter of possessing factual or technically correct information but rests on our belief that the information conforms with our sense of who we are and what we know (Singer, 2004).

THE RELEVANCE OF AUTHENTICITY TO PUBLIC HEALTH

Arguably, constructivism and the corresponding interest in authenticity that has been percolating in various fields and subfields of education for several decades has not had as much impact on public health communication and education as the coining of the term *KAP-gap* might lead one to expect. As many have noted, the overarching reason for this may be that most areas of public health remain deeply invested in the positivist methodological assumptions derived from the model of bio-medicine, in which objectivity, direct observability, and randomized controlled trials are considered the gold standard (Buchanan, 1998; Coreil, 1997; Yoder, 1997).

In contrast to positivism, of course, constructivism places increased emphasis on the learner's relationship to his or her social and material environment. Thus to the extent that constructivism destabilizes our traditional conception of the learning process, it also puts the very notion of objectivity in question. Taking the place of objectivity, among constructivists, has been an interest in how people make different sense of the same phenomenon (E. Green, 1987). For instance, health-related knowledge associated with washing one's hands is radically different for a Western surgeon, a fast-food worker, a Hindu ascetic, or a village woman in the drought-plagued Sahel. Naturally, some commonalities exist (or can be agreed on), but what makes hand-washing an authentic task—its importance, appropriateness, procedures, and its implications—will vary radically from person to person.

Of course, some health educators and communication specialists may object to the suggestion that the field has not been grappling with authenticity in its own way. Indeed, the current interest in "participatory" and social models of communication and education is due in large part to the field's rejection of learner models that, they claim, excessively focus on individuals solving objective problems and ignore the fact that social forces and culture shape knowledge and

action (Scalway, 2003). Participatory approaches are often cast as distinct from traditional, individualistic, and cognitive approaches to behavior change such as the health belief model, social–cognitive learning theory, or the theory of reasoned action in that they are intended to ensure that target populations have an opportunity to contribute information, especially at the formative research stage, that will go on to shape the subsequent intervention. For many public health practitioners in the developing world, especially, working with mass media, community consensus-building, and group mapping exercises to address behavior change is a needed antidote to what is perceived to be a failed and Eurocentric interest in the individual (Airhihenbuwa & Obregon, 2000).

It is ironic, however, that although participatory and other community-focused approaches do, in fact, reject positivism and draw on key constructivist truisms, many such approaches have the effect—if not the intent—of pulling away from authenticity by replacing a model of the autonomous learner with a social model that underemphasizes individual agency and mental representation. By treating groups of people as "communities" (rather than aggregates of individuals with widely varying experiences and perspectives), many social and participatory approaches to public health wash out the everyday differences that lead to variations in individual choices and behaviors. Although social characterization is useful, indeed critical, in undertaking many public health interventions, it is inadequate to the task of authenticating learning. From positions on opposing ends of the epistemological spectrum, both narrowly positivistic and narrowly social models of learning sidestep the importance of authenticity for another reason: because they underestimate the role and nature of persuasion in the learning process.

Persuasion and Authentication

Until relatively recently, persuasion had not been a key concern for public health practitioners with either positivistic or social theoretical leanings, although for very different reasons. Health professionals who are methodologically aligned with the bio-medical tradition tend toward the belief that "facts speak for themselves" (and thus persuasion is unnecessary—even suspect), whereas public health practitioners with a strong cultural bent often focus on social forces and power dynamics and find individuals' processes of representation inconsequential. Yet persuasion is at the core of authentication; authenticity is not an intrinsic property possessed by information, it is a judgment, a decision made on the part of the learner based on prior experience and sociocultural context. However "socially constructed" information may be, it is nonetheless applied by individuals who have been persuaded to apply it.

When the subject of persuasion does, in fact, receive attention in public health, it is generally seen through the methodological and dialectic lens of the decision-making paradigm found in psychology and marketing (cf. Kruglanski & Thompson, 1999; Perloff, 2001; Petty & Cacioppo, 1986; Rimer & Kreuter, 2006; O'Keefe & Jensen, 2007). To suggest the limitations of this paradigm in terms of authenticity, we might consider Jim Connelly's (2002) criticism of the behavior change communication model, which he believes dominates public health communication and education. He argues that current conceptions of behavior

> over-simplify, probably for the reasons of methodological behaviorism, the elaborated complexity, dynamism and crucially discursive and emergent nature of the root conception of personhood. . . . What is at stake here is the appropriateness and scientific status of the outdated metaphor of the computer which still underpins much of cognitive psychology. The centrality of rule-following rather than discourse, behavior rather than meaning and ends-means calculation rather than integrity of personhood over time (narrative biography) are evident in the construct, and overwhelmingly, cognitive psychology adopted in BCC [behavior change communication model] studies. (p. 693)

Both the model of behavior change that Connelly criticizes and the decision-making model of persuasion commonly used in health communication describe the steps and stages that individuals encounter as they weigh claims and come to conclusions (cf. Kruglanski et al., 2006). Persuasion in the decision-making mold (however iterative) is highly procedural, well-structured, and quasi-syllogistic. In contrast to this, a student of persuasion coming out of the field of rhetoric might counter that everyday persuasion is ill-structured and enthymemic: a series of premises not linked by logic but by practical rationality, emotion, and inference. An argument's effectiveness depends on *kairos*—the rhetorical moment that aligns the rhetor's goals and the audience's expectations with the situation at hand. Persuasion, in this rhetorical sense, emerges in the interaction of the rhetor and his or her audience (Burnyeat, 1994). It is not controlled or predetermined by either the rhetor or the audience alone but is coconstructed and constantly evolving.

The attraction of a decision-making, rather than rhetorical, model of both behavior and persuasion is understandable, however. In an age of global public health there are concrete benefits (e.g., funding) as well as scientific benefits (e.g., further model building) that usually require the indexing of interventions to demonstrate efficacy and provide a basis for decisions regarding scale-up and replication. Decision-making models of behavior and persuasion hold out the promise that interventions can be objectively measured and their effectiveness carefully calculated (cf. Porter, 1994). In addition, such modeling permits researchers to identify and isolate important variables in persuasion and propose normative arguments against which atypical arguments can be contrasted.

Although a rhetorical conception of persuasion can make little pretense of scientific rigor, it is almost certainly better suited to the job of authenticating health information because it assumes that information is constantly being

reshaped to meet the needs and expectations of the public. If we are interested in how evidence and arguments make sense to any given individual, rhetorical concepts and literature relating to audience, occasion, and the tentativeness of belief provide a rich framework for describing the process of authentication. Indeed, a now-classic definition of rhetoric is "the function of adjusting ideas to people and people to ideas" (Bryant, 1953). What a rhetorical perspective on persuasion lacks in predictive power, it compensates with a more nuanced description of how attitudes and understandings are changed in real life.

Narration and Authentication

Adjusting perceptions of authenticity may be especially important in the public health field, in which health educators and communication professionals often request audiences to change habits, diet, and a range of risk behaviors. Behavior change is, of course, rarely easy and almost always requires some sacrifice on the part of the person being asked to change. This raises the bar in terms of persuasion; the natural inclination of most members of the public is to resist changes that are disruptive, uncomfortable, or that stymie pleasure. Recommendations to change behavior, accordingly, will not be readily seen as authentic—they will not easily fit in with what individuals believe they know about themselves and their ability to change. Presuming its performer is conscious of it, a health-related behavior will likely seem very three-dimensional; it will have a history, emotional resonance, links to social identity, and extensive connections within memory. From a communication and education perspective, then, what kind of strategy makes the most sense in terms of authenticating ideas about health and behavior change? The short answer is, perhaps, a narrative strategy that contextualizes information in the form of stories, anecdotes, and cases. As Schank and Berman (2002) observe, narrative is an integral part of all learning. "Our minds are structured so that we cannot help but construct stories out of our experiences, and we listen to stories with an innate ability to pull apart the details and fill out our memory structures where they are lacking." (p. 311).

Whereas narrative has been of longstanding interest in the social sciences and communication, scholarship on the topic of health has focused on the psychotherapeutic and clinical practices whereby patients formulate (and potentially rescript) a narrative account of their illness, or doctor–patient interaction usefully takes a narrative form (see Harter, Japp, & Beck, 2005; Mattingly 2001). Conversely, the literature on narrative in public health is much less robust, although it too is growing (e.g., Slater, 2002). It has been noted that public health interventions using narratives naturally lend themselves to creating the psychological space individuals need to integrate new information about new behaviors into an existing web of associations, cause–effect relationships, and experiences (Graesser, Olde, & Klettke, 2002; Kreuter et al., 2007; Petraglia, 2007; Sharf, 1990). Nonnarrative (i.e., propositional) techniques are useful in attracting attention and delivering information, and may even prompt reflection, but they do not offer the opportunity for people to engage with the message and consider all the ways in which the information functions in real life. In other words, they contribute little to the process of authenticating information.

As Jerome Bruner puts it, narrative is a "natural vehicle" for change as it "mediates between the canonical world of culture and the more idiosyncratic world of beliefs, desires, and hopes" (1990, p. 52). Narrative is the means by which to "understand the origins, meanings, and significance of your present difficulties, and to do so in a way that makes change conceivable and attainable" (p. 113). M. C. Green (2004) suggests that

> The phenomenological experience of being lost in a book may produce belief change in several ways: reducing negative cognitive responding, creating attachments to or feelings for characters, and making the narrative world seem more real and narrative events more like personal experience. (p. 248)

And as Sharf (1990) explains, narratives have the power to move public health professionals toward "the desired end of shared understanding, inducing cooperation and improving health care" (p. 223).

Although there are solid theoretical principles recommending the use of narrative to provide an "exploratorium" within which people can try on new behaviors, using narrative persuasively is, at present, more art than science. Although the connection between stories and thought (no less behavior) is inherently dynamic and difficult to determine with any certainty, we may be on safer ground if we accept that narratives promote a kind of *cognitive traction*: a densely textured surface on which members of the public can engage their prior experiences, feelings, and attitudes. Building on the connection between authenticity and narrative, Herrington et al. (2003) suggest that the critical first step someone needs to take to perceive a situation as authentic is the suspension of disbelief.

> Once the initial suspension of disbelief has occurred, it is only inconsistencies within the parameters of the plot itself that cause dissonance in the viewer . . . once the viewer has accepted the fundamental basis for the simulated world in which he or she is immersed, engagement with the story and message of the film is entirely feasible. (p. 60)

A similar observation is expressed in M. C. Green and Brock's (2002) notion of "transportation," which M. C. Green (2006) describes as "an integrative melding of attention, imagery, and feelings focused on story events" (p. S164). Transportation and a narrative's perceived authenticity are closely related. It may be that authenticity creates the conditions in which transportation is most likely to occur, or it might be that the

determination of an issue's authenticity is a consequence of having been transported through imagery and affective engagement. An individual's transportation into a narrative has the potential to tap multiple levels of audience receptivity.

Working through narrative, therefore, may be a fundamental means for bringing authenticity to bear on public health communication. In a narrative intervention, behavior change is accomplished not through the simple awareness of the target behavior we hope one will adopt but through helping would-be risk reducers acquire new strategies for identifying and reaching goals, create new associations or revise old associations in memory, and increase their confidence that they can attain and maintain the behaviors they have been persuaded are necessary for avoiding health risk. But the persuasive use of narrative in public health will lack its full potency until we consider the role dialogue plays in both persuasion and authentication, for, as Harter et al. (2005, p. 11) note, narrative is a social and communicative process that is inherently dialogic.

Dialogue and Authentication

A rhetorical model of persuasion—like constructivist learning theory—would draw our attention to two critical issues: the situatedness of all persuasion (i.e., the unique nature of persuading a particular person of a particular proposition) and, perhaps more important, the fundamentally dialogic nature of persuasion. Of course, dialogue has been intimately connected to persuasion in the rhetorical tradition, with some of the discipline's earlier principles set out in dialogue form and "Socratic dialogue" becoming synonymous with a rhetorical style of both persuasion and education.

Although a comprehensive overview of the ways in which scholars have advanced our understanding of dialogue is outside the scope of this article, Stewart and Zediker (2000) and Zoller (2000) suggest many ways in which dialogue can assist the process of authentication. A key distinction they make is between descriptive and prescriptive theories of dialogue. Descriptive theories are predicated on the "fact" of dialogue and aim at naming its parts, variations, and scope. At its most simple descriptive level, dialogue is described as the discourse individuals exchange to communicate information. "Dialogue," in this narrow sense, is what is captured in the transcription of what one person said to another and how that person responded. Still within the descriptive end of the spectrum, philosophers, rhetoricians, and communication specialists have been keen to highlight the existential nature of dialogue and demonstrate that dialogue is not merely a mechanism of communication but the means by which Selves come into existence. "These descriptive versions of dialogue urge theorists and practitioners to understand human being as irreducibly dyadic or social." (Stewart & Zediker, p. 226).

Prescriptive theories of dialogue, in contrast, assume dialogue's existential import, for the most part, and advance a conception of dialogue that is more ethical or more efficacious. Such theories promote genuine dialogue as a communicative ideal—not merely the means that allow for the exchange of information but a self-actualizing process that creates the conditions for happiness, dignity, and justice.

Theorists in many disciplines have contributed to our understanding of dialogue. In literary theory, perhaps the most cited theorist of dialogue is Mikhail Bakhtin (1981), and perhaps Bakhtin's most cited concept is that of heteroglossia: the inherent multivocality of language that resists neat univocal meaning and undermines the notion that language is a transparent means of communication. In philosophy, Martin Buber (1970) has argued that authenticity—the desire to communicate in a manner that is appropriate and genuine—lies at the core, and pinnacle, of dialogue. Similar to rhetorician Kenneth Burke's (1969) theory of consubstantiality, authenticity is the means by which humans create a sense of self in relation to others.

Whereas humanists have examined dialogue as it relates to ethics and social harmony, for social scientists, the basically dialogic nature of thought itself has been a constructivist mainstay for almost a century (witness Vygotsky's [1981] observation that even "in their own private [mental] sphere, human beings retain the functions of social interaction" [p. 134]). Decision making of all kinds is a product of private deliberation in which a person either pits his or her own conflicting thoughts against each other to arrive at a satisfactory solution or imagines counterarguments that others might make and then seeks to support or refute them. As the Eleatic Stranger in Plato's *Sophist* notes, "thought and speech are the same; only the former, which is a silent argument of the soul with itself, has been given the special name of thought" (as cited in Billig, 1987, p. 263).

For the purpose of authenticating public health information, I propose that dialogue is critical, both because it is inherent in persuasive communication and because it promotes positive human interaction. As Richard Perloff (2001) notes,

> If a [public health] communicator wants to persuade people to change their minds about an issue, he or she must "get into the target audience's heads," and understand how they think about issues, appreciate their mental hang-ups, empathize with their private fears and gear the message accordingly. (p. 68)

But, although sometimes present in theory, in practice, dialogue is not found in most attempts at tailored health communication (THC) and audience segmentation, which, as Perloff's review illustrates, have emerged as the typical public health response to persuasion.

Campbell and Quintiliani (2006) illustrate how THC is based mostly on demographic information and group information about behaviors. In their example of Joe Smith (". . .

45 years old; he identifies himself as African-American; his job involves working 12 hour shifts . . .” [p. 777]) they argue that tailored messages can be designed to influence Joe’s motivation to change behavior. Similarly, Kreuter and McClure’s (2004) review of culture in health communication suggests that the formatting and content of persuasive messaging has focused on four approaches: peripheral (designing elements to fit the audience demographic), evidential (enhancing the relevance of the information by using group-specific evidence), linguistic (adapting messages to the language and register of the target audience), and sociocultural (presenting messages in “in the context of social and/or cultural characteristics of the intended audience” [p. 445]).

THC generally draws from some combination of these four approaches. Accordingly, THC centers on techniques of production/information creation by health communicators and educators. The ways in which tailoring is presumed to work (e.g., match content to an individual’s needs and interests, frame information in a meaningful context, capture the individual’s attention, and provide information in quantities and within channels preferred by individuals) do not presume an ongoing process in which members of the public can ask for clarification, offer counterarguments or rebuttals, or otherwise engage in the kind of coconstruction necessary for authenticating information. So although THC may be well suited to a number of health communication objectives, speaking from the vantage point of rhetoric, without the dialogue necessary to shape the audience’s reaction to the information, THC is only one piece of the puzzle. Transportation, like authenticity, often arises in dialogue. Although an audience presented with a narrative may, on its own, be transported to the world in which the narrative operates (M. C. Green, 2004), it may require “working with” the narrative as part of a dialogic process with the producer/disseminator of the narrative to create both perceptions of authenticity, and thus, transportation.

Because THC recognizes the importance of audience to persuasion, it is a marked improvement over earlier efforts that take the one-size-fits-all approach to health communication. Because tailoring is essentially nondialogic, however, in some fundamental senses it remains tied to the decision-making models of persuasion and instructivist models of learning that inadvertently circumvent questions of authenticity. In public health, the popularity of the IEC (information, education, and communication) paradigm, with its emphasis on information dissemination rather than information application, suggests many of the problems we face in using dialogue. A cynic might argue that IEC is popular precisely because it is not dialogic. IEC is neat: it consists of empirically validated information appropriately packaged (and sometimes tailored) to the audience it is designed to reach. In other words, the distribution of accurate information about behavioral risk and “messaging” designed to inform people of the benefits of behavior change have a commonsense appeal that deflects much scrutiny. It may not be the case that dialogue is not valued or desired but that its “delivery” is expensive and its quality is difficult to monitor and measure. The “value added” of dialogue is also difficult to quantify, and the public health industry is rarely eager to undertake expenses without demonstrating concrete benefits to justify them.

Admittedly, implementing public health communication and education programs with a genuinely dialogic component is logistically and financially demanding, but there are some examples worth considering in this regard. Although I argued earlier that participatory approaches often sidestep issues of agency, some participatory projects are, in fact, designed to accommodate dialogue. Appreciative inquiry, an approach to organizational change that has been adapted for use in public health (Ashford & Patkar, 2001), is notable for its use of participatory methods, not as a means to an end (i.e., only to extract local knowledge that can be fed into the project), but as the end in itself. It works through four stages: discovery, dream, design, and delivery (Cooperrider & Whitney, 2001). An interesting strategy at many levels, for the purpose of this discussion it is relevant for the intensive and ongoing nature of the dialogue it engenders between project implementers and the target population—a dialogue that even blurs the separation between the implementers and the communities they assist. In the discovery stage, community members are brought together to tell stories of personal or community empowerment that are subsequently analyzed to identify personal and communal strengths suggested by the stories. In the dream stage, these strengths are applied to imagine futures (e.g., “Where would you want the community to be in five years?”). The design stage, as the name suggests, moves the group toward planning and concrete action, and the delivery stage encompasses the resultant action.

Two projects with which I have worked closely—MARCH (Modeling and Reinforcement to Combat HIV/AIDS) and RAMP (Reflection and Action Within Most-at-Risk Populations)—are HIV/AIDS prevention projects that directly engage the nexus of narrative, dialogue, and consequently, authenticity. Although they are rooted in different assumptions about role modeling, persuasion, and activity, both projects start with the creation of a narrative component that uses serialized drama formats (using radio, comic books, or video) to model individuals confronting behavioral risk and then provide an “exploratorium” in which audiences can observe the interaction of different variables on that risk. These stories (“role model stories” in MARCH, “behavior change narratives” in RAMP) are developed by a local creative team using the Pathways to Change tools (Petraglia, Galavotti, Harford, Pappas-DeLuca, & Mooki, 2007), which assist them in structuring stories using behavior change theory and site-specific research on behavioral risk.

The tools also ensure that the resultant narratives contain a range of contextually appropriate personal, social, and environmental issues that can be mined in subsequent discussions. The narrative component of both MARCH and RAMP is "designed to describe key characters making their way through life, slowly changing specific attitudes and behaviors. These characters face both positive and negative influences, experience setbacks, seek support in various ways, and, eventually . . . achieve specific behavioral goals" (Galavotti et al., 2005). But this narrative component is only a springboard for the subsequent "reinforcement activities" (in MARCH) or "action phases" (in RAMP) in which health education and communication agents use the stories to prompt dialogue with the audience. This dialogic component is critical to helping listeners see how elements of the serial drama that involve behavior change can help them see their own narratives in a new light.

The RAMP project along the Laos-Thailand border provides an example of how the narrative and dialogic phases of a behavior change project complement each other. In this case, RAMP provides behavior change narratives drawn from research with the four principal at-risk populations: commercial sex workers, soldiers, porters who carry goods across the border, and truckers. The last three groups frequently engage in risky sexual and other HIV-related behavior along the border and bring that risk home to their wives and girlfriends. The stories are conveyed in a series of comic books in which a member of each respective at-risk population is the protagonist. Local health communication and education agents convene small groups of the population with which they work (in this region, different organizations have a mandate to work with different populations) and begin the first of three action phases by asking group members to discuss the story, its main characters, their behaviors, motivations, and choices. Central questions in this dialogic phase of the projects include "How relevant is this narrative for your own problems?" "Would you be able to do what this character did, and if not, why not?" and "How is risk behavior in this community similar to, and different from, that illustrated in this story?"

The use of the behavior change narrative in the action phase sessions help RAMP audiences understand the complexity of the situation being depicted. These sessions seek to structure an exploratorium in which participants comment on—and question—the entertainment value as well as the plausibility of the story; attend to barriers to, and facilitators of, change; and brainstorm ideas for addressing the barriers and facilitators that they perceive as relevant to them and their peers. The facilitation of these sessions is very open; agents are encouraged to stand to one side as participants interrogate assumptions raised both in the story and in the discussion with other participants. At the end of the first action phase, group members are asked to prioritize personal, social, and environmental risks that they feel are most salient within their cohort or community. It is emphasized that prioritization exercises show only tentative consensus—participants in the second action phase are invited to revise the prioritization and decide, as a group, which activities might be collaboratively undertaken to support risk reduction. The final action phase has agents working with individual group members to dissent from the group prioritization (if they wish) and to identify behavioral risks and solutions that the individual feels are most relevant to his or her health.

Although projects based on the principles of appreciative inquiry and those such as MARCH and RAMP are very different in many respects, they share a common commitment to narrative and dialogue, not as incidental or perfunctory, but as fundamental to change. In the case of MARCH and RAMP, narratives are told solely as heuristics—stories that may be valuable because they resonate with individuals' own struggles to change behavior or precisely because they diverge from the individual's experience in ways that provoke thought and action. Each of these projects encourages dialogue in the service of promoting perceptions of authenticity—not authenticity from the perspective of the public health agent, but from that of the individuals who need to apply information and guidance relating to behavior change to their own circumstances.

From personal experience I know that, again, the dialogic aspects of public health communication and education are the most difficult, labor-intensive, and costly from an administrative perspective. The reinforcement component of MARCH and the action phases of RAMP entail extensive organization, logistical preparation, and the training of local reinforcement agents to genuinely facilitate, rather than direct, discussion. None of these is a negligible consideration, of course, but difficulty and expense are not adequate reasons to content ourselves with narratives that do not invite counternarratives. If we genuinely believe in the importance of being authentic, the challenge of dialogue is one that must be met in health education and communication.

CONCLUSION

A quarter century ago, Don Norman (1981) rejected the positivistic information-processing paradigm in psychology—and by extension, instructivism—in the following manner:

> The human is a social animal, interacting with others, with the environment and with itself. The core disciplines of cognitive science have tended to ignore these aspects of behavior. The results have been considerable progress on some fronts, but sterility overall, for the organism we are analyzing is conceived as pure intellect, communicating with one another in logical dialogue, perceiving, remembering, thinking when appropriate, reasoning its way through well-formed problems that are encountered in the day. Alas, that description does not fit actual behavior. (p. 266)

And, alas, we in public health know that the factors that contribute to both behavior and behavior change are a complex mix—unique to each individual—of cognitive appraisals based on past experience, social and normative influences, and environmental factors such as availability of services, laws and policies, and media. Logically, any attempt to encourage behavior change has to operate across all these dimensions. Another corollary is that such attempts must also be adaptive to individuals' perceptions of what is true about themselves and their world and what is possible.

To conclude, then, many health messages are not so much incomprehensible or imprecise as they are inauthentic—they do not jibe with what people know about themselves and the world they live in. Accordingly, the challenge health educators and communicators face has less to do with giving the "right" information than with persuading the learner that information and ideas are relevant to their everyday existence. Like others in the health communication and education field, I have argued that this process unfolds most three-dimensionally when embedded in narratives that simultaneously tap the cognitive, affective, social, and cultural dimensions of behavior. Current discussions of tailoring and of narrative persuasion make important and practical suggestions that public health communicators and educators can take onboard. Tailoring highlights the need to disaggregate "publics" into people, and the use of narratives assists educators in a kind of shuttle diplomacy that negotiates the worlds of public health expertise and life as experienced by individuals. As in any negotiations, however, dialogue is critical, for it is dialogue that permits the interaction that is requisite to both persuasion and authentication.

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