

DESIGNING HEALTH CARE COMMUNICATIONS: USING PSYCHOLOGICAL SET TO ENGAGE AND PERSUADE

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There is really no such thing as a neutral communication. People being who they are with varying healthcare values and priorities react to healthcare communications differently. Understanding and planning for the factors that shape perception and how healthcare consumers react is essential to effective healthcare communications. The most effective communications must be developed with a sound understanding of the various healthcare values and priorities of the target audience, i.e., those factors that define the consumer's psychological set, shape their selective perception, and the likelihood that they will elaborate on the message delivered through an advertisement or marketing communication.

Introduction

Human beings are multidimensional creatures. Feelings of attraction, repulsion or indifference operate simultaneously within us. These feelings vary from issue to issue, and topic to topic.

In a healthcare context, the Profiles of Activities and Attitudes Toward Healthcare (PATH)[™] model demonstrates that there are distinctive patterns of healthcare behavioral traits, intentions and attitudes that shape adult healthcare outcomes. These healthcare outcomes reflect the way adults relate to their own health and the healthcare delivery environment. They define what people focus on, pay attention to, spend time on, and disregard.

The way these healthcare priorities, behaviors and attitudes are related to one another is different from individual to individual. Some adults have a high regard and trust of physicians and avidly seek health information to be better informed. They will be attracted to healthcare information and messages that support their trust in medical professionals. Other adults seek health information to be better informed, but they do so because of their high *distrust* of medical professionals. These individuals are attracted to messages focused on healthcare information, but will resist messages that also attempt to tell them medical professionals can be unquestionably trusted. Still others have a high distrust of medical professionals and *don't seek* healthcare information because they regard nearly all health care information as questionable. These adults will resist messages touting these themes, or at best, react to them with ambivalence.

These complex conditions of varying attraction, repulsion, or indifference need to be understood if communications are to be optimally effective and persuasive. When it comes to predicting how a message is likely to be received, an individual's areas of perceptual vigilance, defense or ambivalence need to be understood. These conditions make up the individual's psychological set, and determine the extent to which a message is attended to, how well it persuades, and how it will be acted upon.

Cognitive State of Readiness (Psychological Set) and Contemplation Activity

An individual's *cognitive state of readiness* (psychological set) consists of those areas that are important, relevant and of high priority. The cognitive state of readiness defines the subject areas that will naturally stimulate attention and increase the likelihood of contemplation. *Contemplation* refers to the way a message is thought about and reacted to. A message that does not speak to an area of relevance or priority will not stimulate attention or much contemplation. This is due to low *perceptual vigilance*. A message that addresses an area of relevance or priority to a person is much more likely to stimulate attentiveness and increase the likelihood of contemplation, i.e., the degree to which the person thinks about the message. That contemplation, however, can be either positive or negative. Which one depends on how well the content of the message *agrees* with the opinions, perceptions, or priorities of the person receiving the message. The greater the agreement, the more likely it is that positive contemplation will take place and the message recipient will think well of the message subject matter. If the message disagrees with the opinions or perceptions of the individual, then the perceptual vigilance will become *perceptual defense* (tuning the message out) and negative contemplation. The message and the message subject matter will be thought of negatively.

The Importance of Fitting the Message To The Cognitive State of Readiness (Psychological Set)

One of the many goals of communication designers is to maximize the potential for message attentiveness, minimize the risk of negative contemplation, and maximize the potential for positive contemplation among a targeted audience. When the message topic is part of the target audiences' cognitive state of readiness, the members can be counted on to be high involvement consumers—they will pay active attention. They will actively learn. In this situation, the communication can provide more detailed information while working to stimulate positive contemplation and avoid negative contemplation. Higher involvement results in greater contemplation and better retention of the message. The key risk in this situation is fostering negative contemplation.

When the topic is not part of the audiences' cognitive state of readiness, members are more likely to be low involvement consumers. They will passively attend to the message and passively learn. Here, the communicator's task is to stimulate and *maintain* attentiveness while working to interject key points. Because the potential for message retention is low, only the basic elements of the message are put forth with increased repetition.

PATH Profiles As A Window To The Cognitive State (Psychological Set)

A PATH profile can be considered a window to the cognitive state of readiness of individuals in a health care context. The healthcare dimension levels that define and describe each profile tells you what an individual thinks about, prioritizes, and gives time to in any given moment—and how strongly these opinions or priorities are held. The multi-dimensional nature of the PATH profile therefore identifies many areas of perceptual vigilance, defense, and potential elaboration in a simultaneous fashion. These insights offer health care marketers and advertisers the ability to craft more effective and persuasive messages.

Demonstrating The Mechanics of Perceptual Vigilance, Defense and Contemplation

To illustrate the mechanics and effect of perceptual vigilance, defense and contemplation on the way a communication is received, a simple example will be used. It will detail the potential impact of a campaign on two different target audiences with different sets of values and priorities.

Figure 1 describes two hypothetical groups of adults with differing levels of concern about five issues described as Dimensions 1 to 5. Segment A represents 38 percent of

Figure 1. Example of Differing Relationships Between Priorities in Two Different Segments

	<u>Segment A</u>	<u>Segment B</u>
Dimension 1	L	H
Dimension 2	H	L
Dimension 3	M	L
Dimension 4	L	H
Dimension 5	H	H

Each dimension represents an issue that adults can consider a low (L), moderate (M) or high (H) priority.

adults and generally shows a 20 percent greater demand for healthcare services. Segment B represents 25 percent of adults and shows demand for healthcare that is 10 percent below the norm. The priority level of each dimension in each segment is described as low (L), moderate (M) or high (H).

First, let's review the differences between the two groups. Segment A adults have low concern for Dimensions 1 and 4, high concern for Dimensions 2 and 5, and moderate concern for Dimension 3. In contrast, Segment B adults have high concern for Dimensions 1, 4 and 5, and low concern for Dimensions 2 and 3. The only issue both groups of adults agree on is the importance of Dimension 5.

It should also be noted that the issues represented by each dimension are not *associated* in the same way in both groups. For example, in Segment A Dimensions 1 and 3 are weakly correlated (low versus moderate); Dimensions 1 and 5 are *negatively* correlated (low versus high). In contrast, Dimensions 1 and 5 are *positively* correlated in Segment B (both high), while Dimension 1 is negatively correlated with Dimensions 2 and 3 (high versus low and low). These two segments have differing *profiles* of concern across common dimensions, i.e., each segment puts different priorities on any given dimension (except Dimension 5).

Let's see what can happen when a single communication fails to reflect the priorities of both segments.

Figure 2 contrasts the fit between a communication’s message and the priorities of Segments A and B. It’s clear that the value propositions of the communication are rarely aligned with the full array of priorities of Segment A or B. Because of this, there is never an occasion where the communication is tapping into the cognitive state of readiness of both segments.

By taking into account the effects of perceptual vigilance and message

Figure 2. Alignment of a Communication with the Differing Priorities of the Two Segments

	<u>Segment A</u>	New Communication Positions	<u>Segment B</u>
Dimension 1	L	L	H
Dimension 2	H	M	L
Dimension 3	M	H	L
Dimension 4	L	H	H
Dimension 5	H	L	L

Each dimension represents an issue that adults can consider a low (L), moderate (M) or high (H) priority.

contemplation to this scenario, the potential impact of the communication on each segment can be anticipated. The rules are as follows: Wherever the communication is in agreement with either segment’s priorities, perceptual vigilance is expected, as is positive contemplation. Wherever there is weak agreement (e.g., M with H or M with L) low vigilance is expected, as is little contemplation of the message. In cases where the communication’s value propositions run counter to either segment, perceptual defense and negative contemplation is expected.

Figure 3 applies these rules to the message in relation to each segment and provides simple scores to identify the overall impact. The rules are: 1) wherever the

communication's level matches a segment's level it receives a (+) standing for positive contemplation and perceptual vigilance, 2) wherever the communication's position is close (e.g., H with M, or M with L) it receives a (0) meaning it stimulates weak contemplation and weak perceptual vigilance, and 3) wherever the communication's level is opposite from the level of any segment it receives a (-) standing for negative contemplation and perceptual defense. Like signs are added together and the negatives are subtracted from the positives to calculate the overall impact.

Figure 3. Response of Segments To Communication

	Segment A	New Communication Positions		Segment B
Dimension 1	L	(+)	L (-)	H
Dimension 2	H	(0)	M (0)	L
Dimension 3	M	(0)	L (+)	L
Dimension 4	L	(-)	H (+)	H
Dimension 5	H	(-)	L (+)	L
Net Communication Effect =		-1	+2	

Potential Reactions to Communication Based on Priority Level

(+) = positive elaboration, perceptual *vigilance*, (-) = negative elaboration, perceptual *defense*, (0) = little elaboration, weak vigilance/defense

Based on this procedure and these simple rules, we get a picture of how the communication performs with each segment. It is easy to see that the communication has a weak positive affinity to Segment B, and a weak negative affinity to Segment A. The communication only achieves 40 percent of the positive contemplation it could from Segment B, while generating 10 percent of the negative contemplation possible in Segment A.

When all is said and done, the communication stimulates more positive contemplation among Segment B, and some negative contemplation and perceptual defense among Segment A.

Putting The Results In Context

Is this good or bad? It depends on who is doing the communicating and for what. If the communicator is attempting to stimulate the greatest mass appeal, the communication is a failure because it tends to appeal to the smaller Segment B and turns off the larger Segment A.

If the communicator is a healthcare *provider* looking to attract those with higher medical demand, the communication is a failure. It achieves some success at targeting

the wrong segment of adults because Segment B adults have lower healthcare demand. The communication compounds the problem by effectively repelling adults in Segment A with the higher demand.

If the communicator is a *health plan* attempting to persuade and attract adults with low demand for healthcare, the communication is a success in two ways: first, it achieves some success at attracting the low demanding adults, and second, it successfully repels those with high demand.

What this example attempts to drive home is that the most effective health care communications must be developed with a sound understanding of the various healthcare priorities of the target audience, i.e., those factors that define the consumer's cognitive state of readiness and shape their selective perception. Also, the choice of communication elements (i.e., triggers) should demonstrate some fit with the cognitive state of readiness of the most important market segment. Communications that do this skillfully will get the help of the target audience in terms of building ad recall and engaging them in positive and persuasive thought.

Conclusions

Psychological and consumer behavior factors come into play (e.g., selective perception, perceptual vigilance, positive contemplation, active learning) when any communication is perceived. There's no way around this. The most effective health communications seek the support of as many of these forces as possible when conveying a message and working to persuade an audience. The application of PATH model principles to healthcare communications design and evaluation provide this essential insight.

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