sciendo
ISSN 1392-1142 (Print), ISSN 2335-8750 (Online)
ORGANIZACIJŲ VADYBA:
SISTEMINIAI TYRIMAI 2022.87
https://doi.org/10.2478/mosr-2022-0003

Arvydas Petras BAKANAUSKAS,
Edita KONDROTIENĖ,
Edita JEZUKEVIČIENĖ

Consumers Believe in Health Behavior but do not Perform it: Understanding Attitude Formation Factors' Influence on Consumer Health Behavior

The article discusses the theoretical aspects of attitude formation, the factors influencing the formation of consumer attitudes and their relationship with consumer health behavior. The second part of the article presents the results of an empirical study revealing a tendency that consumers believe in health behavior but do not perform it. Using the attitude formation factors and the causal-consequential relationship between attitude formation and health behavior there is evaluated and presented the attitude formation impact on health behavior.

Keywords: an attitude, attitude formation, attitude formation components, consumer attitudes, health behavior.

Straipsnyje aptariami teoriniai nuostatų formavimosi aspektai, veiksniai, darantys įtaką vartotojų nuostatų formavimuisi, ir jų sąsajos su vartotojų sveikatos elgsena. Antroje straipsnio dalyje pateikiami empirinio tyrimo rezultatai, atskleidžiantys tendenciją, kad vartotojai tiki sveikatos elgsena, bet jos nevykdo. Pasitelkiant nuostatas formuojančius veiksnius, ir teorinėje dalyje identifikuotą priežasties-pasekmės ryšį tarp vartotojo nuostatų formavimosi ir sveikatos elgsenos, atliekami nuostatų formavimosi poveikio vartotojo sveikatos elgsenai vertinimai.

Raktiniai žodžiai: nuostata, nuostatų formavimasis, nuostatas formuojantys veiksniai, vartotojų nuostatos, sveikatos elgsena.

Introduction

Relevance of the topic. The phenomenon of attitudes and behavior is probably one of the most widely studied areas in psychology and sociology sciences. Different researchers (Abraham, Sheeran, 1993; Ajzen, 2001, 2005; Schwartz, 2007; van Kleef, van den Berg, Heederink, 2011, Chaiklin, 2011; van Kleef, van Doorn, Heerdink, Koning, 2011; Bohner Dickel, 2011; etc.) analysed various individual, emotional, cognitive, psychological aspects and their relationship with behavior though affective, cognitive and behavioural aspects of

Arvydas Petras BAKANAUSKAS – professor at the Faculty of Economics and Management, Marketing Department, Vytautas Magnus University, Lithuania. Address: S. Daukanto str. 28, Kaunas, Lithuania.
Phone: +370 37 327856. Email: arvydas.bakanauskas@vdu.lt
Edita KONDROTIENĖ – Faculty of Economics and Management, Vytautas Magnus University, Lithuania. Address: S. Daukanto str. 28, Kaunas, Lithuania. Phone: +370 37 327856. Email: edita.kondrotiene@stud.vdu.lt
Edita JEZUKEVIČIENĖ – researcher at the Institute of Educational Research, Vytautas Magnus University, Lithuania. Address: Jonavos str. 66, Kaunas, Lithuania. Phone: +370 5 2 279 02 81. Email: edita.jezukeviciene@vdu.lt

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attitudes formation. Analyzing the scientific literature there was identified that an attitude is acquired and accumulated in memory individual, invisible summary individual assessment of certain objects of attitude (objects, people, events, products, services, ideas, social phenomena), individual "umbrella" expression of psychological aspects through attitudes, feelings, emotions, beliefs, expectations, decisions, evaluations and values, ethical, moral, social and other principles formed on the basis of emotional, behavioural or cognitive factors, expressing a certain belief and reaction of the individual to the evaluated object, positive or negative attitudes, positive or negative perceptions to act in relation to the objects being assessed accordingly in certain situations. An analysis of the scientific literature reveals, that an attitude formation is a multi-level process, that takes place by integrating cognitive, affective, and behavioural components and is influenced by certain attitude formation factors.

Studied scientific literature (Blackwell, Miniard, Engel, 2001; Foxal, 1997; O'Shaughnessy, 2012; Gupta 2015; and others) revealed, that health behavior is an exact result of consumer attitude formation process. Behavior itself, in a general sense, is defined as a scientific discipline in consumer psychology that encompasses the processes of individuals, specific consumers, their groups, and organizations in purchasing, purchasing, and using products and services to meet their needs and wants. The concept of behavior may include the behavior of an individual, a consumer, or a group of consumers, but it always encompasses the totality of actions related to the mindset, emotional, and physical behavior of the individual behaving. Medical and health science research includes the term "health behavior", one of the most important scientific disciplines in medical and consumer health psychology, which can make a significant contribution to improving public health. It is a set of education, science, professional skills aimed at maintaining and strengthening public health, disease prevention, any behavior or activity of an individual, actions and habits related to health care, health restoration and improvement, health preservation. These are preventive behaviors and activities of an individual aimed at preventing or detecting diseases at an early stage in order to maintain health or improve general health, diagnosing symptoms before the disease is present.

Health behavior researchers (Corner, Norman, 2000; Amzat, Razum, 2014; and other) are in general prevailed by the trends of consequential health behavior researchers, revealing the outcome of certain individual behavior tendencies: for example, participation or non-participation in health screening programs, following or not following a healthy lifestyle, smoking or non-smoking, etc. However, assessing the consequences of the current health behavior, in light of the deteriorating public health both in Lithuania and globally, growing morbidity statistics of various chronic and autoimmune diseases (hypertension, ischemic heart disease, diabetes, oncological diseases), a question naturally arises about the causes of all these health behavior trends. As attitude is treated as a factor within the individual's control, the science needs research, which, by use of attitude constitution and attitude

formation aspects, would help to reveal the causal motives for individual's health behavior. Research into and knowledge of the factors shaping consumer attitudes could provide opportunities to analyse the causal motives for health behavior. The science also attaches significant importance to research, which reveals how, by way of attitude formation, one could understand, forecast, model and influence the individual's health behavior and through involvement of attitudes formation factors, foresee reasons for such behavior. in order to achieve health-enhancing, health-protecting behaviors and avoid harmful health behaviors.

Scientific problem is formulated, what factors shaping consumer attitudes influence exact consumer health behavior, that consumer believe in health behavior, but do not perform it.

Research target: consumer attitudes formation toward health behavior.

The aim of paper is to analyse the attitude formation factors influence on exact consumer health behavior, by presenting the result of empirical research and indicating the causal-consequential relationship between attitude formation and health behavior, to evaluate the attitude formation factors impact on exact consumer health behavior.

Research methods: In the theoretical part of the article a comparative analysis of scientific literature sources is performed. The analysis of the theoretical literature allows to define the theoretical aspects of the formation of consumer attitudes, to understand the aspects of consumer health behavior, to identify the theoretical links between consumer attitudes and health behavior. With the aim to identify prevailing patterns of health behavior and to measure attitudes' impact on different behavioural strategies, exploratory quantitative research was conducted. Qualitative study design was not chosen because of the need to compare the links between attitudes and health behavior, and it is not the facts that are examined, but consumer experiences (Creswell, 2007). In order to make generalizations about health attitude and health behavior in Lithuanian society, a national representative survey among the 18-65 years old Lithuanian residents was performed. To interview the respondents, CAWI (computer assisted web interview) method was used. Respondents were selected from Norstat panel. Fieldwork was performed from September 1 to October 31, 2021. The questionnaire was designed to cover the theoretical framework of the paper. Analysis of the results was performed using SPSS software. In the first step of analysis, descriptive statistics was used. For summarizing the characteristics of the sample frequencies of answers were calculated, for answers' comparison in different socio-demographical groups crosstabulation technique was used. For exploring relationships between different attitudes and behavior correlation analysis was performed.

The objectives of the article. After analysing the theoretical aspects of the attitude formation factors and their relationship with consumer health behavior to present the results of empirical research indicating the causal-consequential links between attitude formation and exact health behavior thus revealing possible causes why consumers believe in health behavior but do not perform it.

Consumer attitudes and attitude formation

The attitudes could in common be defined as a lasting, general evaluation of people (including oneself), objects, advertisements, or issues: from the absence of an attitudes and neutral reaction to the formation of an exact attitudes toward particular objects. Consumers have attitudes towards a wide range of attitude objects. As the attitudes that we hold affect our behaviour and our intentions, marketers need to understand consumers' attitudes in a variety of circumstances, and to devise means for influencing those attitudes so that consumers adopt more positive attitudes towards the products or services on offer.

The different authors (Chaiken 1993, 2007; Ajzen, 2001; Hogg, Vaughan, 2005; Pratkanis, Breckler, Greenwald, 2014; and others) define the concept of attitudes using terms such as "cumulative evaluation", "acquired over time evaluation" and "favourable and unfavourable evaluation", "umbrella expression", a psychological tendency expressing the evaluation of given objects with a certain degree of favourability or unfavorability, as an covering an individual's personal psychological characteristics (feelings, emotions, values, etc.).

As an attitude has three components (affect, behaviour and cognition), there are some studies of other authors (van Kleef, van den Berg, and Heerdink, 2015) where the concept of the attitude phenomenon is explained using affective (emotional) and cognitive (experiential, knowledge-based) components that form an attitude. Affect is common referring to how a consumer feels about an attitude object. Behaviour in common refers to the intentions to take action about it, and cognition is the perception what consumer believes to be true about the attitude object. Consumers do have lots of attitudes, and we form attitudes every day in our daily life. For example, we are not born with the conviction that Cola is better than Sprite. We form such an attitude.

The attitude formation is a constant process, as individuals belong to certain social groups, organizations, where they are constantly influenced in one way or another. Our attitudes are formed throughout life and are activated when decisions need to be made about specific actions, such as choosing certain products or services, deciding how to behave in specific situations (participating or not participating, buying or not buying, choosing or not choosing, etc.).

Publications of researchers who have studied the phenomenon of attitude formation (Eagly, Chaiken, 1993; Petty, Fabrigar, Wegener 1997; Ajzen, 2001; Pickens, 2005; Van den Berg, et al., 2006; Maio, Haddock, Verplanken, 2019) reveal the influence of cognitive and affective and behavioural assessments on attitudes formation, where an attitude formation is as the result of a multicomponent process, consisting of certain components (cognitive, affective, and behavioural). In the most widely described, three-component model of attitude formation, also called the ABC model in the scientific literature, attitudes formation consists of successive components that can be defined as cognitive (experience, cognition), affective (emotional, emotional) and conative (behavioural) (Figure 1).

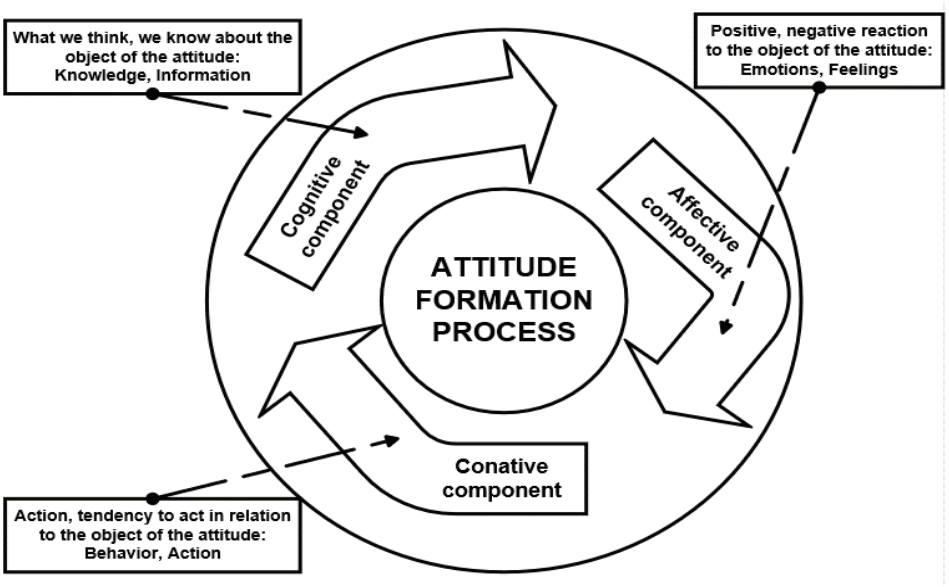


Fig 1. **Three-component model of attitudes formation**

Source: ABC model (Eagly, Chaiken, 1993).

Resuming, an attitude formation, as a multi-level process, takes place not only by integrating cognitive, affective, and conative components, but also by combining certain factors of attitude formation. By forming attitudes, people often rely on their pre-existing knowledge and opinions to ensure they are consistent in their beliefs. This ABC model of attitude formation emphasizes the correlations among knowing, feeling, and doing. First, we form beliefs (cognitions) about an attitude object, then we make positive or negative evaluations about that object (affect), and then we make some actions (behaviour).

Cognitive component (level) of attitudes formation process. An analysis of the literature of researchers (Ajzen, 1985, 2001, 2005; Fishbein, Middlestad, 1995; Sanders, 2010; Hogg, Vaughan, 2011; etc.), revealed that at the cognitive component (level) of attitudes formation, the process of attitudes formation is influenced by cognitive factors: individual experience, knowledge, information, beliefs and opinions about the object of attitude. In general, it can be stated that the cognitive component includes the individual's knowledge, understanding and beliefs about the object of attitude. Individual experience is defined as one of cognitive attitude formation component factors, forming attitudes: the cognitive component of attitudes formation is based on individual evaluation of a certain object, which arises through direct experience with the evaluated object. Another important factor of cognitive attitude formation component is

information factor. The individual evaluation of an object is made on the basis of available information and facts about the object being assessed, evaluating the object's advantages and disadvantages. An example of such an actual assessment could be actual "measurable" assessment criteria such as car fuel consumption, drug strength, and so on. Through these factual evaluations (phenomena, products, services) the objects are identified, separated from each other, and a certain attitude towards them is formed as objects of attitude. Cognition can develop through previous exposure to communications or educational materials. This information includes information stored in an individual's memory and newly received information form external stimuli. The information available in individual's memory and assessed by the individual reflects a positive or negative previous experience with the assessed object. New information can come from external sources of communication and education. The scientific literature (Ajzen, 2005; Oskamp, Schulz, 2014; etc.) finds that information is inseparable from the effects of the external environment – the external stimuli from which it is derived (e.g., advertising, the internet, friends, family, social groups). Thus, the formation of an attitude today is inseparable from the information received from the mass media, from how it represents events. According to the abovementioned authors, the external environment and its relevant stimuli have a particularly important influence on the formation of attitudes and even habits.

In summary, the cognitive component of attitude formation (level) represents certain fact-based individual norms of perception and their limits on what is right or wrong, good or bad, desirable or undesirable (knowledge, experience). It is influenced by the individual's internal evaluations (experience, knowledge gained over time) and information received from external stimuli, based on factual evaluation, and expresses certain beliefs or understandings about the object of attitude on the part of the individual. At the cognitive level, attitudes formation is inseparable from the information, knowledge and information received by the individual through external stimuli. Based on the cognitive aspects of attitudes formation discussed, it is possible to distinguish the factors that influence attitude formation at the cognitive level (Figure 2).

The result of cognitive attitude formation is the actual evaluation of the object, based on available and received information, leading to a specific emotional reaction (affective component of attitude formation).

Affective component (level) of the attitude formation process. Affect in common is conceived of diversified term, that includes emotions, moods, and feelings, as a fundamental aspect of being human, playing an integral role in human motivation, perceptions, social judgments, and impacting various behaviors (Brief, 2001; Forgas, George 2001; etc). The influence of emotions on attitude formation still remains the object of research and is highly controversial in evaluating the attitude formation process. The question arises of how often emotions are used to influence others, whether they actually influence attitude formation, and how strong or long-lasting an attitude is when based on

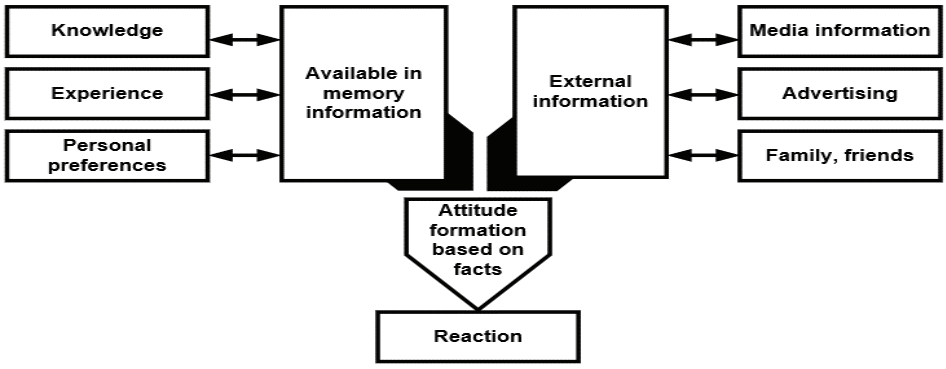


Fig 2. **Cognitive component (level) of attitude formation process and its influencing factors**

Source: composed by the authors according to I. Ajzen (1985, 2001, 2005), M. Fishbein, S. Middlestad (1995).

emotional evaluation that elicits an instantaneous reaction to the object of attitude (DeSteno, Petty, Rucker, Wegener, Braverman, 2004; van Kleef, van Doorn, Heerdink, Koning, 2011; van Kleef, van den Berg, Heerdink, 2015). This is particularly noticeable when assessing the fact that an approach based on emotion is often not based on facts. It can be concluded that emotionally formed attitudes are often difficult for consumers to explain consciously, as they express not only certain feelings, moral beliefs, feelings, but also reveal a certain value system or religious aspects and may change with the situation. For example, consumers may have a negative attitude towards cosmetics or medicines that are tested on animals because it goes against their moral beliefs.

Analysis of the research literature (Ajzen, 2001; Crano, Prislin, 2006; Bohner, Dickel, 2011; Chaiklin, 2011; Greenwald, 2014) reveals, that a certain emotional reaction to the object of attitude occurs, when the attitude itself cannot be based on consciousness or facts, only on emotions. The emotional component of attitudes formation is also called the affective component in the scientific literature, because under the right conditions, it can cause an effect of different intensity – an effect based on specific beliefs. In summary, at the affective level of attitudes formation, attitude formation is based on an emotional reaction to the object of attitude, which evokes particular emotions and leads to a certain expression in action – i.e., the third level of attitudes formation (Figure 3).

The result of the affective attitude formation is a reaction, influencing evaluation of the object of attitude, based on feelings, emotions, and leading to another level of attitude formation – conative (behavioural tendency, action).

Conative (behavioural) component (level) of attitudes formation process. The conative (behavioural) level of attitude formation, a certain expression of attitude happens in action. The conative (behavioural) level of attitude formation

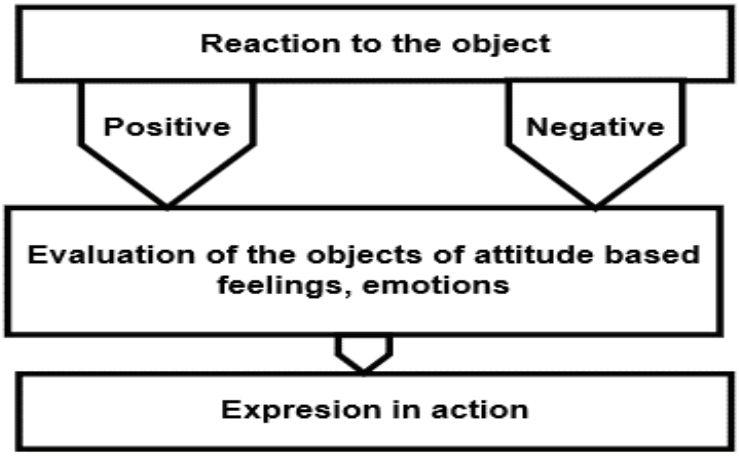


Fig 3. **Affective component (level) of attitudes formation process and its influencing factors**

Source: composed by the authors according to Ajzen (2001), Crano, Prislin (2006), Bohner, Dickel, (2011).

expresses an individual tendency to react with a certain action to a specific object. With the action is expressed the individual's reaction, opinion (favourable/ unfavourable) towards the evaluated object (Ajzen, Fishbein, 1977; Fazio, Zanna, 1978; Ajzen, 2005; etc.). This action is based on an individual's opinion, knowledge the object of the attitude, that consumer has in memory, or observation of the behavior of others. In this observation of others, the evaluation of the behavior of others must influence a certain response of the individual – an action to the stimulus. There is the commitment term in scientific literature, and the degree of commitment relates to their level of involvement with the attitude object (Priester et al., 2004):

1. Compliance – the lowest level of involvement when a person forms an attitude because it helps in gaining reward or avoiding punishment from others. This attitude is very superficial; it is likely to change when another option becomes available (for example, the consumer likes exact sports club, because it is near, and it is too much trouble to go elsewhere.

2. Identification is the level of involvement, when a person forms an attitude to confirm to another person's or group's expectations, or to imitate the behaviour of desirable (for example, consumer likes specific foods, that the friends like).

3. Internalization is a level of involvement, when a consumer internalizes deep-seated attitudes, and these become part of his value system. These attitudes are very difficult to change because they are so important to the individual. For example, many consumers had strong attitudes toward Coca-Cola and reacted quite negatively when the company attempted to switch to the New Coke formula in the 1980s. This allegiance to Coke was obviously more than a minor preference for these people; the brand had become intertwined with their social

identities and took on patriotic and nostalgic properties.

These degrees of personal involvements illustrate, how the attitudes are formed, with observation of others behavior and under influence of others. In general, a behavioural component is a verbal or non-verbal expression of an individual's emotional response, even propensity, toward certain things, consisting of actions or observable reactions, arising from assessing one's own knowledge of an object of attitude or observing the behavior and actions of others with respect to the evaluated object and leading to a certain expression by action = behavior (Figure 4).

At the conative (behavioural) level, attitude formation is a verbal or non-verbal expression of an individual's emotional reaction, arising from assessing one's own knowledge, experience, information (cognitive factors) of the object of attitude, or observing the behavior or actions of others.

The result of all the three attitudes formation components (levels) is an attitude formation stage. The three levels of attitudes formation (cognitive, affective, and behavioural) can be defined as causal components of attitudes formation. And the expression of an attitudes in action or behavior is the consequence of attitude formation. Assessing this, it is possible to assume a causal-consequential relationship between attitude and behavior (Figure 5).

An attitude and its formative factors could be the cause of behavior, and behavior is in turn the expression of attitude in action: consequence, result. In summary, it can be stated that there is a direct connection between attitudes formation factors, attitude and behavior, where an attitude is the result of the attitude formation process, influenced by certain

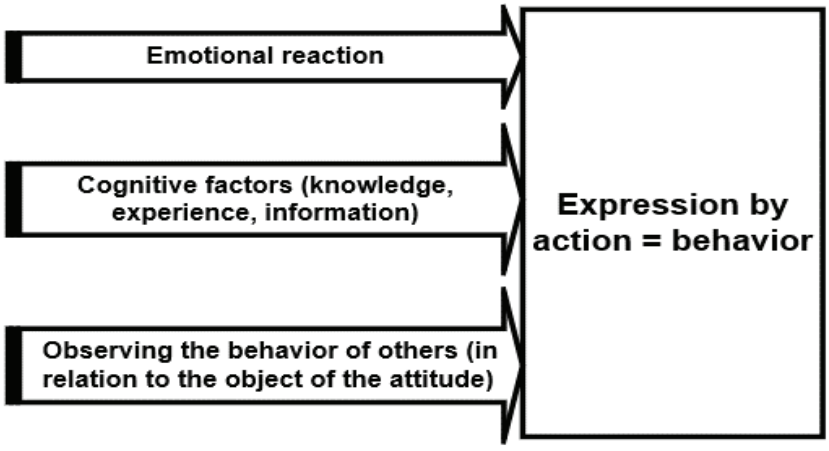


Fig 4. **Conative (behavioural) component (level) of attitude formation process and its influencing factors**

Source: composed by the authors according to I. Ajzen and M. Fishbein (1977), R. H. Fazio and M. P. Zanna (1978), I. Ajzen (2005).

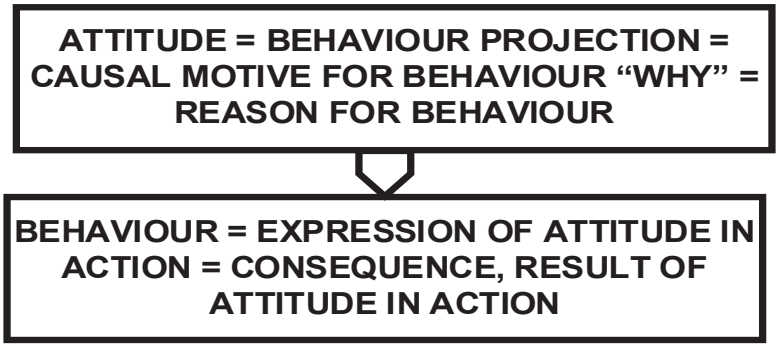


Fig 5. **Causal-consequential relationship between attitude and behavior**

Source: composed by the authors.

causal attitude – forming factors (cognitive, affective, and behavioural) leading to expression of an attitude by an action. Assessing this causal-consequential relationship, it is possible to model the causal-consequential attitudes formation toward behavior model in various research areas (for example, health behavior), the three levels of attitude formation (cognitive, affective, and behavioural) can be defined as causal components of attitudes formation and are influenced by the specific factors, that shape the attitude, and health behaviour – as a result of all attitude formation process.

Consumer health behavior as a result of attitude formation process

Consumer behavior includes many actions of an individual or consumers, a variety of activities, experience and ideas occurring as individuals, consumers or consumer groups are becoming potential consumers of a product or service. In the cognitive psychological aspect, consumer's or individual's behavior is a reflection of consumer's attitude, habits and intentions, including consumer's or individual's perception, learning, emotion, personal traits, etc. (Solomon, 2004; East, Sigh, Wright, Vanhude, 2017; etc.).

The discipline of medical and health psychology defined the term "health behavior" as any behavior or activity, actions and habits of an individual, which are related to health care, health restoration and health improvement (Corner, Norman, 2000; and others). Other scientists (for example, Stroebe, Stroebe, 1995; and others) link the concept of health behavior to a certain lifestyle of an individual, which is affected by our health habits and attitude. In the broad sense, the health behavior phenomenon covers any activity, which is aimed at preventing diseases or detecting them in early stages and improving general health:

- it is health improving behavior (for example, exercising, following healthy nutrition standards),
- health protecting, preventive behavior (for example, participation in health screening programs, vaccination),

- avoidance of harmful behavior (for example, avoiding smoking and excessive alcohol consumption).

The World Health Organization uses the term "health prevention", also known as "disease prevention", for explanation a health behavior, to describe a set of measures to protect, enhance and restore health and prevent disease in order to reduce the burden of disease and related risk factors in order to create a healthier society and reduce unnecessary costs for the healthcare system (WHO definition). Thus, health behaviors can also be defined as preventive behaviors related to the actions a consumer takes in the interest of health until they experience the first symptoms of the disease. It is a preventive health behavior that includes all preventive, non-medical (non-medicated) health conditions and their improvement (from exercise, healthier eating, to vaccinations), a whole range of individual actions (from weight control, diet control, the rest control). Thus, health behaviors can be equated with preventive health behaviors to the extent that the consumer is not yet ill. Health prevention behaviors may include diagnostic tests, various examinations, participation in pre-existing disease prevention programs, and vaccinations. It's also a lifestyle, a habit, something a user can do on their own to prevent disease. Moreover, preventive health behaviors include preventive measures that ensure the well-being of public health, such as wearing seat belts in the car, complying with occupational safety requirements at work, safe sex, and so on. Preventive health behaviors also include the use of preventive preventive measures (such as the use of food supplements), the harmonization of psychological and nervous conditions (such as meditation, prayer), the management of environmental risks and health effects (reduction of pollution in the environment, air, water), and so on. (Norman, Corner, 2005; Armitage, Corner, 2000; and others). As by analysis of scientific literature was identified, that consumer health behavior is an exact result of an attitude formation process (Figure 6).

In this attitude toward health behavior formation model, the three levels of attitude formation (cognitive, affective, and behavioural) could be defined as causal components of attitude formation and are influenced by the specific factors, that shape the attitude. For example, cognitive attitudes formation components, like media information, family members influence, could be defined as the causal components, that shape attitudes and lead to exact attitudes expression by behavior (the result, consequence). Empirical research using the causal factors shaping consumer attitudes, could provide opportunities not only to measure attitude formation factors impact on exact consumer health behavior, but also to understand the causal motives for such a behavior.

Research methodology

With the aim to identify prevailing patterns of health behavior and to measure attitudes' impact on different behavioural strategies, exploratory quantitative research was conducted. The quantitative study was chosen because it enables to compare variables and data, establish relationships between attitudes and behavior (Biklen, 1992; Gay, Diehl, 1992;

Best, Kahn, 1993; Bogdan, Kumar, 1996; Cruswell, 2007; and others). In order to make generalizations about health attitudes and health behavior in Lithuanian society, a national representative survey among 18-65 years old Lithuanian residents was performed. Survey sample size was determined using online sample size

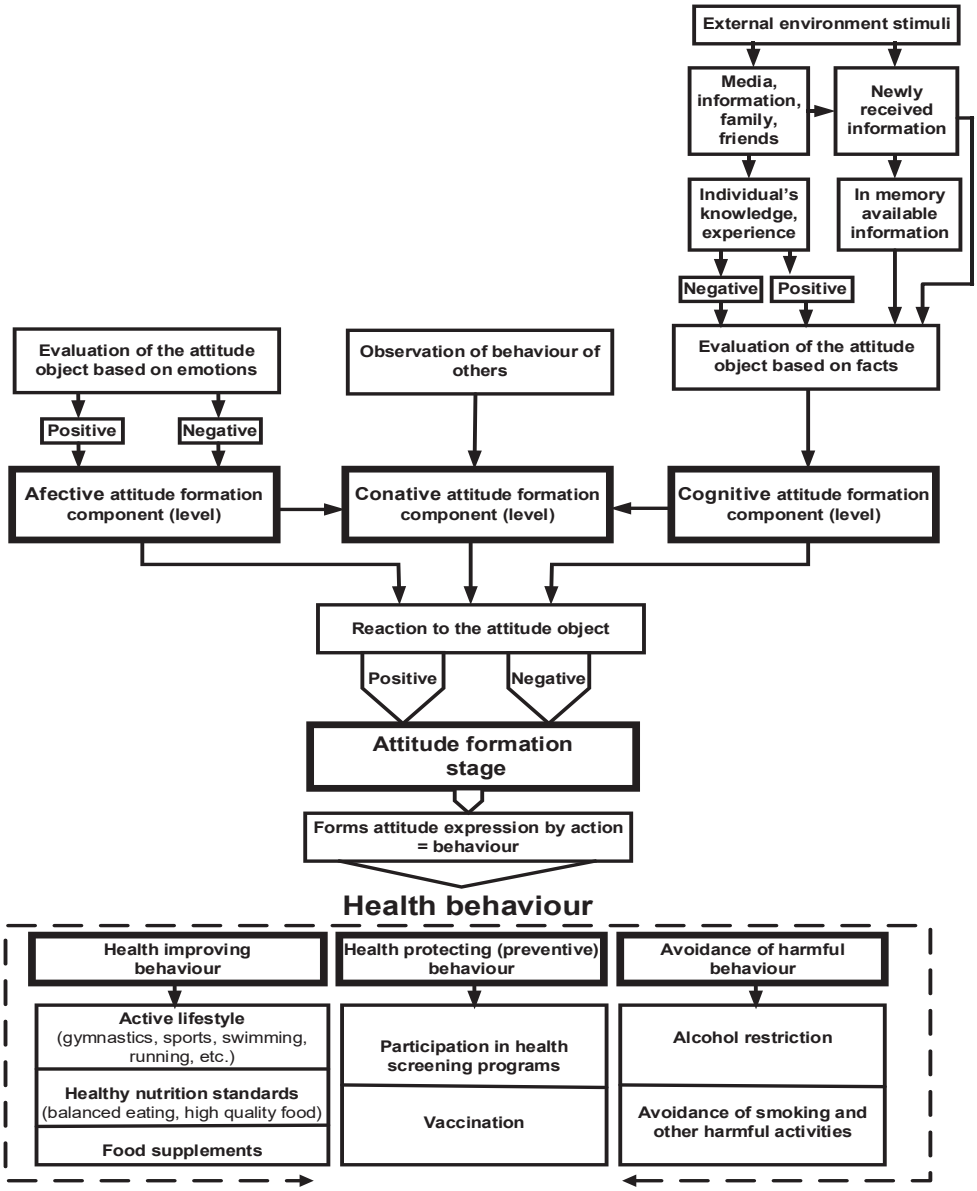


Fig 6. **Health behavior as a result of consumer attitude formation ant its components**

Source: composed by the authors.

calculator. It was decided to interview 1000 respondents which would allow to analyse the results with a confidence level of 99% within ±4% margin of error.

Sampling was performed in several stages. In the first stage, the general adult population was divided into strata – five major Lithuanian cities and ten counties. The number of respondents in each stratum was determined based on the residents' population data of The Lithuanian Department of Statistics. In the second stage, quotas on age and gender were applied.

To interview the respondents, CAWI (computer assisted web interview) method was used.

Respondents were selected from Norstat panel. Fieldwork was performed September 1- October 31, 2021.

The questionnaire was designed to cover the theoretical framework of the paper. In the first part of the questionnaire different aspects of health-enhancing behavior, health-protecting behavior and avoidance of harmful behavior were presented to respondents in the form of statements. In the second part of the questionnaire, statements reflecting different attitudes towards health behavior were presented. Respondents were asked to express their opinion on each statement. 5 – point Likert scales were used (1) Definitely no; (2) Rather no; (3) Neither yes nor no; (4) Rather yes; (5) Definitely yes. One more section of the questionnaire explored information sources on health behavior (health specialists, mass media, seminars, etc.) – their usage and trustworthiness' perception in the society. Other sections of the questionnaire included satisfaction with different aspects of life – not only physical and emotional health, but also satisfaction with one's relationships, occupation, income and in general feeling happy.

As the analysed scientific literature revealed, the attitudes and attitude formation are closely related not only to internal consumers evaluations (perceptions, knowledges), but also to external stimuli (for example, information from family). For that reason, the questionnaire focused not only on identifying respondents' demographic profile (age, education, place of residence), but also on broader characteristics such as their parents' education, occupation, which might be important criteria in shaping attitudes.

Analysis of the results was performed using SPSS software. In the first step of analysis, descriptive statistics was used. For summarizing the characteristics of the sample frequencies of answers were calculated, for answers' comparison in different socio-demographical groups crosstabulation technique was used. For exploring relationships between different attitudes and behavior correlation analysis was performed.

Demographic profile of all the respondents (N=1000). As the analysed scientific literature revealed, the attitudes and attitude formation are closely related not only to internal evaluations (individual perceptions, knowledges), but also to external stimuli (for example, information from family), the demographic portrait of all the respondents plays a significant role in the empirical research.

Respondents by gender: women N=500, men=500.

Respondents split by age: **22.2% are 18-29 years old**, 21.4% are 30-39 years

old, 21% – 40-49 years old, **23.7 % – 50-59 years old**, and 11.7% – 60-65 years old.

Respondents split by location: **five biggest cities – 43.4%,** other cities – 23.9%, settlement, village – 32.7%.

Respondents split by family status: single – 20.5%, **live in partnership/ engaged/family – 67%,** divorced – 9%, widow/widower – 3.5%.

Respondents that grew up with both parents until they became adults (under 18) – **76.4%.** The mother of the respondents worked full time until they were 18 years old – **76.2 %,** the father worked full time until the respondents reached the age of 18 – **85.7%.**

The father's education: professional – **32.4%,** PhD – 1.2%, university bachelor and master – 19%, non-university bachelor and master – 10.9%, school – 13%, not finished school – 14.6%.

The mother's education: professional – **23.4%,** PhD – 1.2%, university bachelor and master – **23.5%,** non-university bachelor and master – 15.9%, school – 14.1%, not finished school – 14.6%.

Respondents split by education: **university bachelor and master – 51.3%**, non – university bachelor and master – 19.5%, professional – 15.2 %, PhD – 1.1%, school – 11.6%, not finished school – 1.3%.

Respondents according to the social status of occupation**:** permanently unemployed 3.8%, not working because have a disability 2.7%, temporarily unemployed, looking for work 5.4%, studying 6.1%, **working/employed 71.3%**, on parental leave 4.9%, in retirement 3.7%, other 2.1%.

Respondents according to the work position (N-713): 16% work in a general managing position; **55.5% specialist, manager;** 10.8% work in the service area; manual work – 14.3%; other – 3.4%.

Resuming the demographic profile of the vast majority: the main part of all the respondents is 18-59 years old, the main location – five big cities, family status – engaged, partnership/family, grew up with both of parents (until 18), the father's education – professional, the mother's education – professional, occupation – working/employed; position – specialists/manager.

Research results

The survey results revealed the tendency, that almost 40% of the Lithuanian population believe in health prevention (health behavior), but do not perform this. The research results are presented in Table 1.

As we can see from the results presented in the table above, **the demographic profile** of such people who believe in health behavior but do not perform it is the following:

- the first main part – people of 18-29 years old, more men than women, Lithuanian, adults (44%);
- the second big group are people of 30-49 years old, more men than women, Lithuanian, adults (40%);
- educated (university bachelor, the biggest part of respondents having master);
- the biggest part of respondents live in 5 big cities;
- the biggest part of respondents live in family/partnership;
- no significant differences were found in comparison of occupation and work position.

Table 1. **The research (Attitude toward health behaviour) results**

Demographic profile	Psychological profile and attitudes	Attitude formation factors shaping such a behaviour	Result (health behavior)
The first main part of respondents is 18-29 years old, more men than women, Lithuanian, adults (44%)	Although they have positive attitudes about health behavior (support the need to move, the importance of a balanced diet for health, preventive diagnostics checks, in order to avoid harmful habits) this is not reflected in their behavior	**Cognitive attitude formation (shaping) component – personal beliefs, knowledge (factors):** they do not tend to look for information about health, they are less likely to look for information in the media, on the Internet, in health education seminars.	Believe in health behavior but do not perform it
The second big group of respondents are people of 30-49 years old, more men than women, Lithuanian, adults (40%)	This behavior is typical for those who spend a lot of time at the computer, watching TV or other technologies.	**Cognitive attitude formation (shaping) component – personal beliefs, knowledge (factors):** they themselves are not interested about the knowledge of health, the deepening of knowledge.	
Educated (university bachelor, master), the biggest part of respondents – live in five biggest cities	They more often do not avoid harmful habits.	**Cognitive attitude formation (shaping) component – personal beliefs, knowledge (factors):** they have the belief, that too much undeserved attention is paid to health, that there is a lot of controversial information about health	
The smallest group of them – divorced	In this group, healthy eating habits are less common, a moderate and complete diet is less necessary, the consumption of inferior products is more common, and caring about physical condition and emotional health are less frequent.	**Cognitive attitude formation (shaping) component – external information (factors):** they are lost in the abundance of information, because they believe there is a lot of controversial information about health	
No significant differences were found comparing parental occupation and work position	They are less satisfied with their mental emotional physical health than those who perform health behavior.	**Cognitive attitude formation (shaping) component – external stimuli: information from doctors, pharmacists (factors):** they receive information on health from doctors and pharmacists (82% of all who believe but do not perform health behavior).	
	They consider that too much undeserved attention is being paid to healthy lifestyles.	**Affective attitude formation component – fear, feelings (factors):** they have a strong sense of fear, i.e., fear of getting sick (more than those with health behavior).	

Continuation of Table 1

Demographic profile	Psychological profile and attitudes	Attitude formation factors shaping such a behaviour	Result (health behavior)
	They consider that there is a lot of controversial information about health behavior.	**Behavioural (conative) attitude formation component:** they are less likely to have a behavioural factor than those with health behaviors (i.e., to take care about health because the parents have taught that).	

Source: the authors' results.

- more respondents whose mother and father have professional education, grew up with both parents and they both worked all the time;
- no significant differences were found comparing parental occupation or work position.

As we can see from the received results, **the psychological profile** of people who believe in health behavior but do not perform it is the following:

- although they have positive attitudes about health behavior (support the need to move, the importance of a balanced diet for health, preventive diagnostics checks in order to avoid harmful habits) this is not reflected in their behavior;
- this behavior is typical for those who spend a lot of time at the computer, watching TV;
- they more often do not avoid harmful habits;
- in this group, healthy eating habits are less common, a moderate and complete diet is less necessary, the consumption of inferior products is more common, and caring about physical condition and emotional health is less frequent;
- they are less satisfied with their mental emotional physical health than those who perform health behavior;
- they consider that too much undeserved attention is being paid to healthy lifestyle;
- they consider that there is a lot of controversial information about health behavior.

As we can see from the results in the table above, **the big impact for such behavior has cognitive attitude shaping factors,** less frequent is influence of affective and behavioural attitude shaping factors of such the behavior. As have been identified in the scientific literature analysis before, the cognitive attitude formation component (level) represents certain fact-based individual norms of perceptions and their limits on what is right or wrong, good or bad, desirable or undesirable. It is influenced by the internal information available in individuals' memory (available in memory, internal personal evaluations – experience, knowledge, personal preference, gained over time) and new external information (new information from external stimuli – media, advertising, family, friends, etc.), based on factual evaluation, and expresses certain consumers beliefs or understandings about the object of attitude and leading to an exact reaction. As we can see form the results above, the cognitive attitude shaping factors, influencing

consumer behavior – *believe but do not perform* – are the following:

- **Cognitive attitude formation component and its factors – personal beliefs, knowledge:** consumers do not tend to look for information about health, they are less likely to look for information in the media, on the Internet, in health promotion seminars, or look for information on the Internet portals about health. They are lost between information (they consider that there is a lot of controversial information). They probably lack motivation or time as they believe that too much undeserved attention is being paid to healthy lifestyles. Maybe it is a question about priorities and time management, because this is the technologies generation, i.e., people who spend a lot of time at the computer, watching TV and other technologies.
- **Cognitive attitude formation component and its factors – external stimuli (information from doctors or pharmacists)**: they receive information about health from doctors and pharmacists (82% of all who believe but do not perform health behavior). It is likely that there is a need of greater involvement of doctors and pharmacists as opinion leaders.
- The results reveal that there is **an affective attitude formation component impact on health behavior** (*believe but do not perform)* **and its components (fear, feelings)**. People who believe in health behavior but do not perform it have a strong sense of fear, i.e., fear of disease (more than those with health behavior);
- **There is no significant influence of behavioural (conative) attitude formation** component and its factors on behavior *"believe but do not perform"*. Such consumers are less likely to have a behavioural factor than those with health behavior (i.e., taking care about health because their parents have taught them it).

Health behavior as a result of consumer attitude formation process *(Figure 6). According to this, and the received results (Table 1), we can identify causal-consequential relationship between attitude formation factors and the exact health behavior (Figure 7).*

The result of all the attitudes formation components (levels) is an attitude formation stage. This is a specific outcome of having a positive or negative attitude towards certain objects under the influence of certain attitude-forming factors. Empirical research revealed, that consumer believe in health behavior, but do not perform it. This behavior is the expression of attitudes in action and is influenced by the specific factors, that shape the attitude (Figure 7):

- **Cognitive attitude formation component and its factors:** information from external stimuli (pharmacists, doctors, and internal stimuli) and consumers' knowledge about health behavior beliefs, perceptions.
- **Affective attitude formation component and its factors:** negative feelings and fear of disease.

These are the attitude formation components and factors, that influence exact formed consumer attitude towards health behavior (e.g., there is a need to move, the importance of a balanced diet for health, preventive diagnostics checks,

in order to avoid harmful habits) and lead to exact reaction and behavioural tendency: although they have positive attitudes about health behavior (support the need to move, the importance of a balanced diet for health, preventive

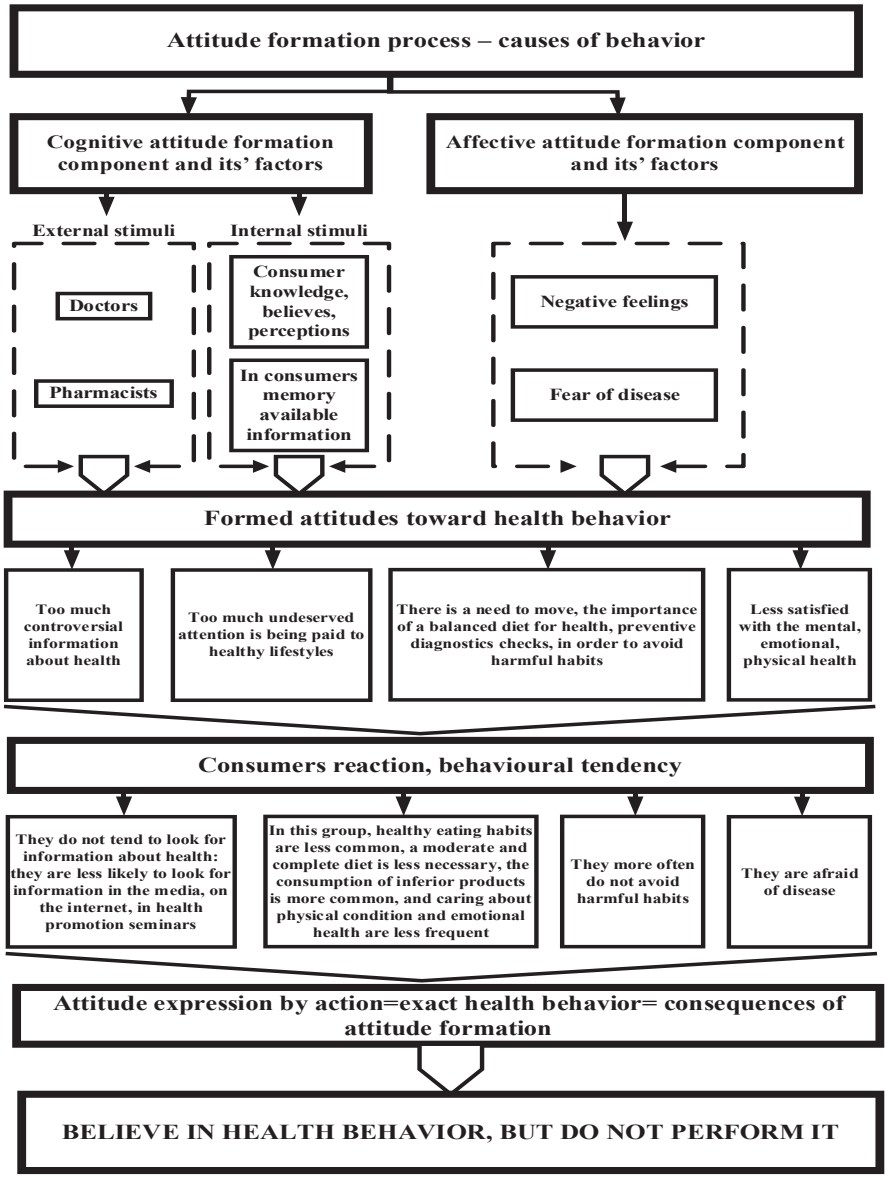


Fig 7. **The causal-consequential explanation of the relationship between attitude formation and health behavior (*believe but do not perform*)**

Source: composed by the authors.

diagnostics checks, in order to avoid harmful habits) this is not reflected in their behavior. This attitude expression by action leads to exact health behavior, the consequence of attitude formation – believe in health behavior, but do not perform it. As Figure 7 illustrates, the two attitude shaping components (cognitive and its factors, as well as affective and its factors) are the causes of the exact health behavior and the attitude expression by and action, so is the consequence of the formed attitudes towards health behavior:

- consumers who believe in health behavior but do not perform it **have personal beliefs, knowledge, perceptions,** that too much undeserved attention is paid to health and there is a lot of controversial information about health. As they do not tend to look for information about health, they are less likely to look for information in the media, on the Internet, in health education seminars, but they get information from doctors and pharmacists, and trust this information. Involvement doctors and pharmacists could help consumer to distinguish controversial information from reliable, and not get lost in the abundance of information;
- consumers who believe in health behavior but do not perform it have strong expressed **fear of disease feeling**, more as consumers with health behavior. It is possible that active involvement of doctors and pharmacists could help consumers not only to distinguish controversial information from reliable and not get lost in the abundance of information, but also give more information about prevention and health behaviour, how to avoid diseases and the economic, psychological, sociological, physiological consequences. It is possible that knowledge about the prevention of disease is likely to reduce fear of disease;
- it is possible that consumers who believe in health behavior but do not perform it **had not got enough reliable information about health from their family in childhood**. As the results show they are less likely to have a behavioural factor than those with health behaviors (i.e., taking care about health because their parents have taught them it). The demographic profile of this target group reveals that consumers who believe in health behavior but do not perform it, do not have strong formed childhood attitudes about health, especially evaluating from the parental education perspective – more respondents are with professional mother and father education. The empirical research revealed, that there is no significant influence of behavioural (conative) attitude formation component and its factors on behavior *"believe, but do not perform"*. This is the causal consequential explanation of the relationship between attitude formation and health behaviour – believe but do not perform.

Conclusions

Summarising the analysed scientific literature, it was identified that an attitude is acquired and accumulated in individual memory, an invisible summarised evaluation of certain objects of

attitude (people, events, products, services, ideas, social phenomena), an expression of psychological aspects of an individual's "umbrella" through feelings, emotions, beliefs, expectations, decisions, knowledge, evaluations and values; ethical, moral, social and other principles formed on the basis of emotional, behavioural or cognitive expression, expressing a certain belief and positive or negative reaction to the evaluated object, and a positive or negative disposition to act towards the evaluated objects in certain situations. Extending this definition of attitude to cognitive and affective aspects, it can be stated that attitude is influenced by experience, accumulated over a long period of time and expressed in a certain situation as a set of individual invisible beliefs, positive or negative feelings, a certain perception of the object of attitude (whether product, idea, phenomenon, event or problem), with an appropriate emotional response to an abstraction or a specific object or statement that can lead to a particular action.

Attitude formation is the result of a multicomponent process consisting of certain components (cognitive, affective, and behavioural). The causal-consequential relationship between attitude formation and health behavior reveals that the three levels of attitude formation (cognitive, affective, and behavioural) could be defined as causal components of attitudes formation. And the expression of an attitude by action or with behavior is the result of the formed attitude.

Empirical quantitative research revealed that approximately 40% of the Lithuanian adults believe in health behavior but do not perform it. Although they have positive attitudes to health behavior (support the need to move, the importance of a balanced diet for health, preventive diagnostics checks in order to avoid harmful habits) this is not reflected in their behavior.

Assessing the results (Table 1), it is possible to identify causal consequential links between attitude formation and health behavior (Figure 7) and understand the causal motives of exact consumer health behavior. There is a significant impact of cognitive attitude formation component ant its factors (internal cognitive factors: beliefs, cognitions, perceptions and impact of external cognitive stimuli: information from doctors, pharmacists) and affective attitude formation component and its factors impact (fear, feelings: a strong sense of fear, fear of disease, more than those with health behavior). There is no significant influence of behavioral (conative) attitude formation component on behavior "believe, but do not perform": they are less likely to have a behavioural factor than those with health behaviors (i.e., take care about health because their parents have taught it).

The results presented in Table 1 and Figure 7 reveal that consumers (who believe in health behavior but do not perform it) are less likely to look for information in the media, on the internet, in health education seminars, but they get reliable information from external sti-muli – doctors or pharmacists. It is likely that greater involvement of doctors and pharmacists in this target segment could contribute to the promotion of consumer health behaviors in order to protect health, strengthen health and prevent harmful behaviors. It is probable that the involvement of doctors and pharmacists, as opinion

leaders in this target group, could help to strengthen the cognitive component of attitude formation, to help to distinguish controversial information from reliable, and not get lost in the abundance of information. By strengthening the cognitive attitude forming factors it is possible to stimulate more interest, get more information, deepen knowledge about health behavior. These are guidelines for further research.

There is significantly expressed attitude forming component and its factor – fear of disease (behavior 'believe but not perform it'). It is possible, that with the help of doctors and pharmacists this target group (who believe but do not perform health behavior) could get more information about health behavior, and the ways how to avoid diseases and the economic, psychological, sociological or physiological consequences. It is possible that knowledge about the prevention of disease is likely to reduce fear. These are guidelines for further research.

There is no significant behavioural attitude shaping factors influence on behavior when consumers believe in health behavior but do not perform it. But there may be significant impact on parental education (the respondents who believe but do not perform health behavior grew up with the parents having professional education). Increasing the involvement of parents in the children's health behavior and education (strengthening the behavioural attitude forming factor) it could be possible to stimulate more interest, get more information, deepen knowledge about health behavior. These are guidelines for further research.

Common tendencies from research about attitude and health behavior: the older the person is, the more significant he believes in health behavior, the more significant this is represented in the behavior. The older a person is, the more he/she cares about his/her health. The younger a person is, the more characteristic is the behavior 'believe but do not perform it'.

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The paper submitted: March 17, 2022
Prepared for publication: August 10, 2022

Arvydas Petras BAKANAUSKAS, Edita KONDROTIENĖ, Edita JEZUKEVIČIENĖ

VARTOTOJAI TIKI SVEIKATOS ELGSENA, BET JA NESIVADOVAUJA: NUOSTATŲ FORMAVIMOSI VEIKSNIŲ ĮTAKOS VERTINIMAS

Santrauka

Straipsnyje apibrėžiami teoriniai nuostatų formavimosi aspektai bei aptariami nuostatas formuojantys veiksniai bei jų sąsajos su vartotojų sveikatos elgsena. Analizuojant mokslinę literatūrą identifikuota, kad nuostata įgyjama ir kaupiama atmintyje kaip individualus, nematomas suvestinis tam tikrų objektų (daiktų, žmonių, įvykių, produktų, paslaugų, idėjų, socialinių reiškinių) vertinimas, individo „skėtinė" psichologinių aspektų išraiška per nuostatas, jausmus, emocijas, įsitikinimus, lūkesčius, sprendimus, vertinimus ir vertybes, etinius, moralinius, socialinius ir kitus principus, suformuota emociniu, elgsenos arba kognityviniu pagrindu, išreiškianti tam tikrą individo įsitikinimą ir reakciją į vertinamą objektą, teigiamą arba neigiamą nusiteikimą veikti atitinkamai vertinamų objektų atžvilgiu tam tikrose situacijose.

Išanalizavus straipsnio mokslinę literatūrą identifikuota, kad nuostatų formavimas yra keleto lygmenų procesas, vykstantis integruojant kognityvinį, afektinį ir bihevioristinius komponentus, kurie jungia tam tikrus nuostatas formuojančius veiksnius. Analizuojant nuostatas formuojančius veiksnius ir panaudojant mokslinės literatūros analizę, modeliuojamas teorinis nuostatas formuojančių veiksnių, jų sąsajų su sveikatos elgsena modelis, atskleidžiantis priežasties-pasėkmės sąsajas tarp nuostatas formuojančių veiksnių ir sveikatos elgsenos bei leidžiantis numatyti tokios elgsenos priežastis. Bendras teorinis nuostatas formuojančių veiksnių ir jų sąsajų su sveikatos

elgsena modelis atskleidžia galimybes, kaip pasitelkiant nuostatas formuojančius veiksnius būtų galima vertinti ne tik individo elgsenos pasekmes, bet ir numatyti šios elgsenos priežastis. Antroji straipsnio dalis skirta empiriniam tyrimui ir vieno iš tyrimo metu gautų rezultatų apžvalgai ir jų vertinimui. Antroje straipsnio dalyje pateikiami empirinio tyrimo rezultatai, atskleidžiantys tendenciją, kad maždaug 40 proc. suaugusių Lietuvos gyventojų tiki sveikatos elgsena, bet jos nesilaiko. Nors jų nuostatos teigiamos (palaiko poreikį judėti, subalansuotos mitybos svarbą sveikatai, profilaktinius diagnostinius patikrinimus, siekiant išvengti kenksmingos elgsenos), tai neatsispindi jų elgsenoje. Pasitelkiant nuostatas formuojančius veiksnius, teorinėje straipsnio dalyje identifikuotą priežastinį – pasekmės ryšį tarp vartotojo nuostatų formavimosi ir sveikatos elgsenos, atliekami nuostatų formavimosi ir sveikatos elgsenos sąsajų vertinimai, kas padeda suprasti tikslios vartotojų sveikatos elgsenos priežastinius motyvus. Didelę įtaką vartotojo nuostatoms dėl sveikatos daro kognityvinis jų formavimosi komponentas ir jo faktoriai (vidiniai kognityviniai veiksniai): vartotojo įsitikinimai, pažinimas, patyrimas, suvokimas. Tai pat reikšminga išorinių kognityvinių stimulų įtaka: gydytojų, vaistininkų informacija ir afektinio nuostatų formavimosi komponento bei jo veiksnių įtaka (baimė, jausmai). Tie, kuriems būdinga elgsenos tendencija, „tiki sveikatos elgsena, bet jos nevykdo“, turi ryškų baimės jausmą, ligos baimę. Elgsenos (kognityvinis, bihevioristinis) nuostatų formavimosi komponentas neturi reikšmingos įtakos vartotojo elgsenai „tiki, bet nevykdo“: šie vartotojai rečiau turi bihevioristinį nuostatų formavimosi komponentą nei besilaikantys sveikatos elgsenos (t. y. nėra linkę rūpintis sveikata, nes tėvai neišmokė). Vartotojas (tikintis sveikatos elgsena, bet taip nesielgiantis) rečiau ieško informacijos žiniasklaidoje, internete, sveikatos mokymo seminaruose, tačiau patikimą informaciją gauna iš išorinių stimulų – gydytojų, vaistininkų. Tikėtina, kad didesnis gydytojų ir vaistininkų įsitraukimas į šį tikslinį segmentą galėtų prisidėti prie vartotojų sveikatos elgsenos skatinimo, siekiant sveikatą saugančios, ją stiprinančios elgsenos ir užkirsti kelią kenksmingai elgsenai. Tikėtina, kad gydytojų ir vaistininkų, kaip nuomonės lyderių, įtraukimas į šią tikslinę grupę galėtų padėti sustiprinti kognityvinį nuostatų formavimosi komponentą, padėti atskirti kontroversišką informaciją nuo patikimos, nepasiklysti informacijos gausoje (ką šie vartotojai ir nurodė). Stiprinant kognityvinį nuostatas formuojantį komponentą būtų galima paskatinti didesnį domėjimąsi, gauti daugiau informacijos, pagilinti žinias apie sveikatos elgseną. Kadangi vartotojai, kurie tiki sveikatos elgsena, bet taip nesielgia, turi didesnį baimės jausmą (ligos baimės, ligos padarinių baimės) nei tie, kurie laikosi sveikatos elgsenos, gali būti, kad su gydytojų ir vaistininkų pagalba ši tikslinė grupė galėtų gauti daugiau informacijos apie sveikatos elgseną, kaip išvengti ligų ir jų pasekmių – ekonominių, psichologinių, sociologinių, fizinių. Tikėtina, kad žinios apie ligų prevenciją galėtų sumažinti baimę. Tai yra tolesnių tyrimų gairės.