Attitudes

- ATTITUDES have EVALUATIVE, AFFECTIVE and CONATIVE components, and must be distinguished from OPINIONS, VALUES, BELIEFS, INTENTIONS and BEHAVIOURS.
- STEREOTYPES are erroneous beliefs about the world, which sometimes contain a kernel of distorted truth.
- Attitudes can be measured by questionnaire, using LIKERT SCALES, with a number of alternative answers which cover the range of feelings.
- In the THEORY OF REASONED ACTION behaviours depend upon intentions, which are themselves determined by attitudes and by NORMATIVE BELIEFS.
- Attitudes can be formed by classical conditioning, or by MERE EXPOSURE, but more often are influenced, in the INFORMATION-PROCESSING MODEL OF ATTITUDE CHANGE, by PERSUASIVE MESSAGES.
- COGNITIVE DISSONANCE, which occurs when attitudes and behaviour are inconsistent, is unpleasant and results in a change in either attitude or behaviour.

People differ not only in their personality, which is relatively fixed over long periods of time, and in their emotions, which are transitory, but also in their attitudes, which do change but over a fairly slow time period, from days to weeks to years. Attitudes and beliefs underlie many major life decisions, as in a patient's decision to visit (or not visit) a doctor, to take treatments, to change to a healthier life-style, etc., and they also underlie many decisions by *doctors* to use treatments or to abandon old ones, to use particular treatments for particular patients, etc. Important decisions are often necessarily based on incomplete information, and attitudes help to rationalize and justify our decisions.

ATTITUDES must be distinguished from OPINIONS, BELIEFS, VALUES and INTENTIONS, although sometimes attitude is also used to describe the whole complex of terms (as in the title of this chapter). One definition of attitude is as follows:

'A relatively enduring cluster of feelings, emotions and behaviours relating to persons, objects and issues, which constitute a mental 'state of readiness', and which are derived and organized from experience.'

An attitude is therefore related *to* a particular behaviour, and involves an EVALUATION of the behaviour as good or bad in terms of some ultimate criterion. Thus one might have an attitude that 'People should be discouraged from smoking cigarettes'. This attitude might exist because one has BELIEFS (i.e. knowledge or facts about the world), which say that 'Cigarettes lead to a premature death', and a set of VALUES (i.e. ultimate goals of life), which say that people should live healthy lives because lives should be lived to the full. Having an attitude that people should be discouraged from smoking does not, of course, perfectly predict behaviour; I may hold such an attitude and be willing to tell people not to smoke in my office, or to ask them to stop smoking in No Smoking compartments of trains, but still not be willing to destroy cigarette advertisements or commit arson on tobacconist shops. For each actual BEHAVIOUR I also have an INTENTION as to whether or not to perform it. Intentions are related to attitudes, but are also influenced by NORMATIVE BELIEFS, which are a set of social beliefs concerning how other people think about the behaviour; or rather, what we *think* other people think about the behaviour. Thus if a stranger lights a cigarette in a railway No Smoking compartment I am more likely to protest if my travelling companions are four fellow doctors than if they are strangers. My attitude remains the same, but its relation to actual behaviour has been altered by how I perceive the normative beliefs of my companions. There is therefore a long chain between values and the behaviours derived from them. The chain is fragile and easily broken, particularly by social pressure. Figure 12.1 summarizes this model which is based on Fishbein's THEORY OF REASONED ACTION, although other models also exist.

Attitudes do not only have an EVALUATIVE dimension, and a CONATIVE or behavioural dimension, they also have an AFFECTIVE or emotional component, so that we may feel angry, happy or sad according to whether or not our attitudes are consistent with the events of the world, and it is this which accounts for much of the importance of attitudes. I might therefore not only *think* that people should be discouraged from smoking, but also *feel* angry that they are not. In this way mere OPINIONS are distinguished from attitudes by the absence of conative or affective components; so that, if asked 'Do you think that more money should be spent on research into particle physics?', you may have an opinion about it (Yes or No), but will probably not have any strong, passionate feelings.

Why do we have attitudes? The world is a complex place, in which decisions continually need to be made and frequently sufficient information is not available, or we do not have time to allow us to obtain such information in order to make a fully informed, rational judgement. In such cases, which can be about everyday events, as well as about more complex MORAL or ETHICAL judgements, attitudes act as a pre-packaged, off-the-peg set of behaviours which we have
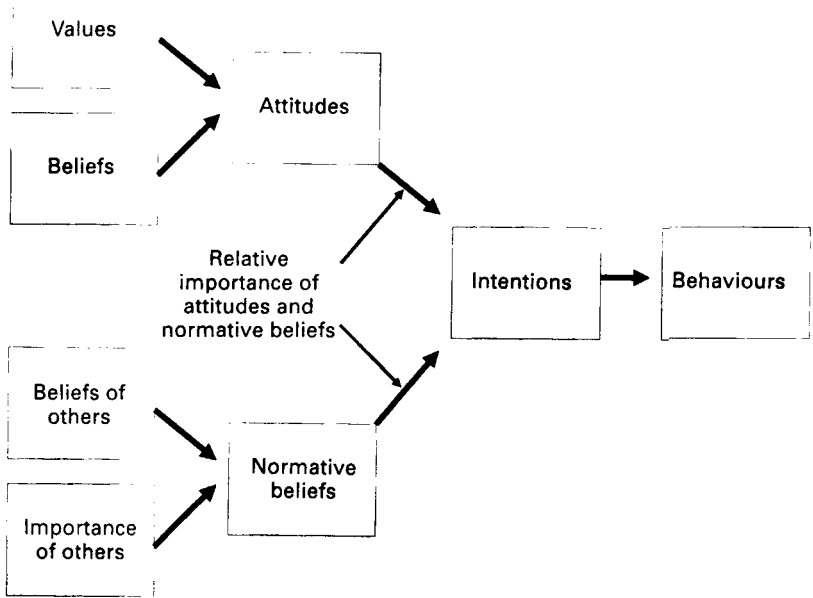
Fig. 12.1 A summary of the Theory of Reasoned Action. Adapted from Ajzen I and Fishbein M (1980), *Understanding attitudes and predicting social behaviour*, New Jersey, Prentice-Hall.

used in previous situations and on which we can rely to some extent. They are therefore convenient and efficient, although no one would claim that they are perfectly reliable.

A variant on the attitude is the STEREOTYPE, which is an erroneous pseudo-factual belief about the world, which when combined with particular values necessitates particular attitudes. Stereotypes can distort the average position — 'Psychiatrists are very left-wing'; and they may reduce the variance — '*All* psychiatrists are very left-wing'. As a matter of empirical fact, psychiatrists are indeed more likely to vote Labour than are surgeons, but this neither justifies describing them as *very* left-wing, nor as assuming that they are *all* left-wing; indeed many psychiatrists vote Conservative. But this example also reveals another feature of stereotypes, that at their heart they often contain a kernel of statistical truth, which has been distorted and exaggerated. Like attitudes, stereotypes are useful in creating a simplified world, which allows action in the absence of better information.

The measurement of attitudes is easily and straightforwardly carried out by questionnaires, although the apparent simplicity of their construction often belies problems encountered in measuring precisely what is intended. Typically, attitude questionnaires like LIKERT SCALES in which are indicated the strength of an attitude using a 5- or 7-point scale, ranging from 'Strongly in favour...' to 'Strongly

opposed . . . '. Table 12.1 shows the attitudes to abortion in applicants to medical school, assessed on a four-point scale.

Normative beliefs can be assessed by a similar method but asking individuals to complete questions that start 'Most people who are important to me think that . . . ', rather than 'I think that . . . '. And beliefs can be assessed by questions starting 'It is true that . . . '.

Attitudes do not just exist, but must have come from somewhere, and since, as social phenomena, it is inconceivable that they are genetic, they must be acquired by learning. And once formed they can also be changed. If health education is to be successful, that process of change must be understood.

Attitudes can be learned by classical conditioning, simple association inducing an attitude. The object (say, a packet of cigarettes or the brand name) is the conditioned stimulus (CS), which is repeatedly paired with an unconditioned stimulus (US), such as a picture of a racing car, which induces an unconditioned response (UR) of excitement, interest or a generally positive feeling, perhaps by secondary conditioning. Eventually the CS, the cigarettes, produce a similar response, the conditioned response (CR). As legislation restricts cigarette advertising so such sophisticated advertising is more common; indeed some adverts are now so cryptic that the pleasure of solving the problem is itself the UR to the CS.

Attitudes can also be changed by MERE EXPOSURE. Repeated presentations of a stimulus make it preferred when a choice is allowed — a psychological process also exploited by cigarette manufacturers who emblazon logos or motifs on the clothes and equipment of sports stars.

Nevertheless, most attitudes are not formed by simple learning, but result from more complex cognitive analysis. People are continually receiving MESSAGES on aspects of the world about which we have attitudes. Whether or not these messages change our attitudes depends on several things; the CONTENT of the message — does it seem reasonable, well-argued, consistent with the known facts? the SENDER of the message — is it a source which we usually trust (such as a particular friend or our regular newspaper) or one which we distrust (a particularly suspect politician or an advertiser), so that we reject the content entirely as unreliable? and is it CONSISTENT with our current attitudes — and if not, but is a well-reasoned message from a source we trust, what do we do? This is the INFORMATION-PROCESSING MODEL of attitude change; like an idealistic mental Parliament we listen to debate, assess the worth of arguments, and change our attitudes accordingly. Sometimes however change does not occur when it should; individuals with particularly strong, polarized political attitudes may deny the validity of all messages thereby avoiding the need for change. Alternatively, if particularly enamoured with the sender of a message, huge changes can occur so that attitudes are consistent with those of the sender.

Table 12.1

The attitudes to abortion of 325 applicants to St Mary's Hospital Medical School in 1981, who indicated their feelings using a four-point response scale. In 1986, another 1937 applicants were asked three of the questions, and the percentage replies are indicated in brackets, to show the remarkable consistency over a five-year period. The items were originally asked in random order, but here have been rearranged in order from those for which most are in favour to those for which most are opposed.

"In which of the following situations in which an abortion has been requested would you think that it should be performed?"

	Definitely yes	Probably yes	Probably no	Definitely no
A woman with congenital heart disease who is unlikely to survive the rigours of childbirth.	76%	20%	2%	2%
A 13-year old girl who has been raped.	75% (74%)	19% (19%)	3% (4%)	3% (4%)
A 25-year old woman who has been raped.	59%	28%	9%	4%
A woman known to be definitely bearing a fetus with spina bifida.	49% (44%)	38% (38%)	7% (11%)	5% (8%)
A woman who might have had German measles earlier in pregnancy.	20%	47%	24%	9%
A 38-year old mother of six.	19%	39%	28%	14%
An unmarried woman who is pregnant as a result of failed contraception.	16%	33%	33%	18%
A woman who has failed to use any form of contraception.	5% (6%)	23% (24%)	38% (39%)	34% (31%)

Inconsistencies between attitudes and behaviours have provoked much research, especially into the problem of COGNITIVE DISSONANCE, in which two separate attitudes or beliefs are held, each mutually inconsistent with the other. Dissonance is unpleasant and induces change in order to reduce the tension. A time-worn but nonetheless pertinent example from Leon Festinger, the founder of COGNITIVE DISSONANCE THEORY, considers a person who smokes cigarettes but knows that cigarettes cause cancer. The statement 'I smoke cigarettes' is inconsistent with the statement 'Smoking is dangerous to health'. There are many ways to reduce the dissonance: to deny the evidence ('there is no proper *experimental* evidence in man, only correlations' or 'My grandfather smoked until he was 95 and was then run over by a bus'); to deny that one's own form of smoking is dangerous ('I only smoke 10 a day' or 'I smoke filter cigarettes'); to invoke social support ('All my friends smoke so it can't be very dangerous'); or to deny the fundamental values involved ('I'd rather have a short pleasurable life than a long miserable one'); finally, smoking may be used as a positive virtue, flaunting the machismo, devil-may-care aspects ('The dangers don't worry me, I'm man enough to cope with them'). In all such cases, defence mechanisms (see Chapter 11) have been used to reduce dissonance. From such a perspective man appears not to be a ration*al* animal but a ration*alizing* animal.

Cognitive dissonance theory has stimulated a series of ingenious experiments to test its predictions. Some experiments study FORCED COMPLIANCE, in which a person behaves inconsistently with their attitudes (as when a teenager smokes to impress friends, even though feeling it to be wrong). In the laboratory, subjects have acted as subjects in a long, tedious and very boring psychological experiment. Dissonance is then induced by asking the subjects to tell the next group of subjects that the experiment was very interesting. Subjects were paid $1 or $20 for taking part. As part of the debriefing, subjects were asked how interesting they found the experiment. Surprisingly, those paid $1 rated the experiment as far more interesting than those paid $20. The group paid $20 had no cognitive dissonance; they had done a boring experiment, had lied about it, and had been paid well, which justified their attitude and they could therefore truthfully say the experiment was not enjoyable. However, the $1 subjects were in a different situation; they had wasted a lot of time on a tedious experiment, had lied, and had been paid a paltry one dollar, which hardly justified their effort. Their only way of reducing the dissonance between effort and reward was to claim the experiment *was* actually interesting, thereby justifying their exertions. Many a doctor looking back on the long hours of learning the endless facts of anatomy or biochemistry, or contemplating the long sleepless hours of the pre-registration year, also justifies it retrospectively by arguing for its

actual interest or real utility; and once more cognitive dissonance has altered attitudes.