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The Influence of Attributional Styles on Understanding the Concept of Health: a Phenomenological Approach

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Abstract

The article demonstrates that attribution theory originated from the work of Haider, who believed that individuals are motivated to view their social life as orderly and controlled. This means that they need to understand cause-and-effect relationships. In an attempt to explain why a person's assessment of their own risks can be wrong and why people can be unrealistically optimistic, Weinstein suggests that, in such cases, a mechanism of selective focus is triggered, whereby individuals ignore their own behaviour that increases risks and focus on behaviour that reduces risks or does not affect them.

The article emphasises that media campaigns to promote healthy behaviour and prevent unhealthy behaviour have become one of the main tools for public health professionals trying to improve the outcomes of their work. The article concludes that the main media messages of the campaign are often complemented by other approaches, such as distributing educational printed materials or creating a news stream on the campaign topic, particularly when budgets for buying airtime or media space are limited.

Keywords

attribution, style, reasoning, interpretation, health, illness, psychology, media

Introduction

The origins of attribution theory can be found in the work of Heider (Heider, 1958), who believed that individuals are motivated to view their social lives as orderly and controlled, which means they need to understand cause and effect. Kelley developed (Kelley, 1971) the

very first principles of attribution theory, which suggested that attributions of causality are structured according to a certain scheme based on the following criteria:

- Specificity: the attribution for the cause of a certain behaviour is specific to the individual who performs that behaviour;
- Consensus: the attribution for the cause of a certain behaviour must be supported by others;
- Stability over time: the same attribution for causality must be derived at any other point in time;
- Stability in context: the same attribution must be derived in a different situation.

Kelly believed that people make attributions according to these criteria and that the type of specific attribution (e.g., high salience, low consensus, low time stability, low context stability, etc.) determines the extent to which a causal factor in behaviour is seen as the result of intrinsic (inherent in the individual) or extrinsic (inherent in the environment or situation) characteristics.

Methodology

The theoretical and methodological basis of the study was formed by the following approaches and conceptual provisions: systemic and functional approaches (Ananiev, 2001; Anokhin, 1975; Lomov, 1975; Maksymenko, 1990); resource approach and coping studies (Biron, 2015; Maltsev, 2017; Rodina, 2013; Lytvynenko, 2021; Kireieva & Turlakov, 2024); concepts of internal picture of health (Kagan, 1988), cognitive representations of illness and health (Bishop & Converse, 1986; Leventhal, 1975; Taylor et. al., 1991), health perception (Goodwin & Engstrom, 2002; Peterson, & De Avila, 1995; Reis, Reis, & Kunde, 2025); theory of attributional style (Abramson et. al., 1991; Seligman et. al, 1979); cognitive concept of basic beliefs of the individual in the works of R. Yanov-Bulman, adaptation by O. Kravczova (Savchenko & Svyryda, 2020); theory of dysfunctional attitudes and irrational attitudes (Beck, 19836 1987; Ellis, 1962); scientific concepts of: deficit-ambivalent forms of personification and inferiority of the personality (Maltsev & Lunov, 2020; Maltsev, 2020); the role and importance of the internal picture of health in the life of the personality (Markova & Markov, 2016; Lunov, Matyash, Abdrakhimova, Pavlov, & Dzeruzhynska, 2024).

To solve the research objectives and ensure objectivity, a number of methods were used:
Theoretical methods:

- Theoretical analysis of sources;
- Systematic and structural analysis and interpretation of the obtained data.

Empirical methods:

- Neuromonitoring of subjects during structured interviews;
- Modelling;
- Analysis;
- Standardised and valid psychodiagnostic and neuropsychological methods.

To determine the attributional style of the internal health perception, the attributional style test was used by L. Rudina (Attributional Style Test, 2022). Methods for diagnosing the presence and severity of irrational attitudes (Ellis, 1962), Scale for assessing the complexity and uncertainty of the situation (Vodopianova, 2009); coping strategies for mediating experience were assessed using the Methodology for Identifying Cognitive and Behavioural

Coping Strategies (I. Syzova, S. Filipchenkova (*Computer Psychological Diagnostics — Methodology.* (n.d.)); the Methodology for Studying the Life Satisfaction Index was used to assess the personal conditionality of the internal picture of health.

Analysis of Recent Research

Over time, significant progress has been made in the theory of attribution, particularly in distinguishing between self-attributions (i.e. attributions about one's own behaviour) and attributions about others (i.e. attributions about the behaviour of other people). Additionally, the main criteria have been supplemented and reformulated as follows:

- Internal versus external (e.g., I cannot get a job because of the employer's bias or because I did not behave convincingly at the interview);
- Stable — unstable (e.g., the reason for my job search failure is one specific event or there is always a clue);
- General — specific (the reason for my failure to find a job affects other areas of my life or only this particular interview);
- Controlled — uncontrollable (the reason for my failure at the interview is beyond my control or I can control it).

Brickman et al. (1982) also distinguished between attributions about the causes of a problem and attributions about its possible solution.

For example, an alcoholic may believe that they are responsible for their alcoholism due to a lack of willpower (cause attribution) and also believe that medicine is responsible for bringing them back to a healthy lifestyle (solution attribution).

Attribution theory has also been applied to the study of human health and related human behaviours. For example, Bradley (1985) studied patients' attributions of responsibility for their diabetes and found that a sense of control over the disease ("Do I (or significant others) have control over my diabetes?") influenced their treatment choices. Patients could choose among the following options: 1) an insulin pump, a miniature mechanical device that is fixed to the skin to provide a constant supply of insulin; 2) intensive conventional treatment; 3) continue with daily insulin injections.

The results showed that patients who chose the insulin pump demonstrated less control over their own disease and more control attributed to omnipotent doctors. Thus, if a person externally attributed their illness and felt that they were not personally responsible for their illness, they were more likely to choose an insulin pump and more likely to transfer responsibility to doctors. A further study by King (1982) found a correlation between attributions about the disease and regular visits to the hospital to be checked for hypertension. The results of the study showed that if patients viewed hypertension as external but controllable, they were more likely to make a diagnostic visit to the hospital ("I am not responsible for my hypertension, but I can control it"). The dichotomy "external — internal" proposed by attribution theory has been widely used in the concept of locus of control over health.

Here, people differ in whether they view events as controlled by themselves (internal locus of control) or controlled by external factors (external locus of control). Wallston and Wallston (1982) developed the Locus of Control Scale, which assesses the extent to which a person views his or her own health as being under their control ("I am directly, directly responsible for my health") or believes or believes that his/her health is influenced by happy/unhappy

accidents ("Whether I get sick or not is just a matter of good or bad fortune"), or considers his/her health to be in the hands of powerful others ("I can only do what my doctor allows me to do"). Locus of control over health is related to whether an individual changes their own behaviour (e.g. quitting smoking) and to the style of communication they require from health professionals. Although the concept of locus of control in health seems scientifically productive, there are several problematic issues:

- Is locus of control a state or a characteristic of the individual? ("Is my locus of control always internal?")
- Is it possible to have both internal and external locus of control?
- In terms of locus of control, is a visit to the doctor an act of external control (the doctor is a powerful other who can improve my condition) or internal control (I determine my own health by choosing the time and regularity of interactions with doctors)?

Weinstein (1987) suggested that one of the reasons why people continue to engage in unhealthy behaviours is because they have inaccurate assessments of risks and vulnerabilities, or unrealistic optimism. The researcher asked the subjects to read a list of various health problems and assess whether, compared to other people of the same age and gender, they were more likely to have such a problem — higher, lower or about the same. The results of the study showed that most respondents consider themselves less likely to experience various health problems. Weinstein called this phenomenon "unrealistic optimism" because he believed that not every patient would show such a frivolous attitude in risk assessment. The scientist describes (Weinstein, 1987) four cognitive factors that have the greatest impact on the development of unrealistic optimism:

1) a lack of personal experience with this particular problem;
2) the belief that the problem can be prevented by individual efforts;
3) the belief that if the problem has not arisen so far, it will not arise in the future;
4) the belief that the problem is, in principle, rare.

The combination of these factors indicates that the perception of one's own risks may not always be a rational process. In an attempt to explain why a person's risk assessment may be wrong and why people may be unrealistically optimistic, Weinstein (1987) suggests that a mechanism of selective attention is at work in such cases: Individuals ignore their own behaviour that increases risks ("I may smoke a little, but it's not that important") and focus on behaviour that reduces risks or does not affect them ("At least I don't overeat"). The researcher also emphasises that such selectivity is based on egocentrism — a person is likely to ignore the behaviour of others aimed at reducing risks ("My friends don't smoke, but it doesn't matter").

In a study by Hoppe and Ogden (1996), participants were asked to focus on behaviours that reduce risks ("safe sex") or those that increase them ("unsafe sex"). The researchers examined unrealistic optimism about HIV risk. Heterosexual participants were asked to fill out a questionnaire about their beliefs about HIV and their sexual behaviour. The participants were then divided into two groups, based on increasing or decreasing risk. Participants in the higher-risk group were asked to answer questions such as "How many times since you started having sex have you asked your partner about his/her HIV status?", as the researchers assumed that only a few participants in this group would report doing so frequently. For those in the lower-risk group, the researchers asked questions such as "How often since the beginning of your sexual activity have you carefully selected your partners?"

The results of the study showed that shifting the focus to factors that reduce risk for the subjects increased their optimism due to the relative increase in the risks of other people in the perception of the participants themselves.

The transtheoretical model of behavioural change was developed by DiClemente and Prochaska (1982) as a synthesis of 18 therapies that covered various processes of behavioural change initiation and maintenance; it is now better known as the Stages of Change Model (SOM). Prochaska and DiClemente identified common processes in different therapeutic approaches and techniques and proposed a new model of behavioural change based on the following stages:

1) Pre-contemplation: there is no intention to make any changes.
2) Contemplation: considering the possibility of change.
3) Preparation: making minor changes.
4) Action: actively engaging in the new behaviour.
5) Maintenance: implementing and maintaining the behavioural change over time.

These stages, however, do not always occur in a direct sequence (simply moving from 1 to 5) — the stages of change model describes behavioural change as flexible and dynamic. For example, a person may move to the Preparation stage and then back to the Contemplation stage, and so on several times in a row before finally moving to the Action stage. Furthermore, even when a person reaches the maintenance stage, they may eventually revert back to the contemplation stage. The Stages of Change Model also describes how a person weighs the benefits and costs of a particular behaviour.

In particular, the authors of the model argue that individuals at different stages of change focus differently on both the costs ("Quitting smoking makes me irritable in public") and the benefits of a particular behaviour ("Quitting smoking improves my health"). For example, smokers in the action ("I have stopped smoking") and maintenance ("I have not smoked for two months") stages tend to focus on the positive and beneficial aspects of the behaviour ("I feel healthier because I have stopped smoking"), while smokers in the pre-contemplation stage tend to focus on the negative aspects ("Quitting will make me irritable"). The stages of change model has been applied to such human behaviours as smoking, drinking, exercise, and undergoing diagnostic medical procedures (Marcus et al., 1992).

The application of the model to smoking cessation involves the following set of beliefs and behaviours at different stages:

1) Contemplation: "I am happy with the fact that I smoke and plan to continue smoking."
2) Contemplation: "I have been coughing a lot lately. Maybe I should think about quitting smoking."
3) Preparation: "I will not smoke in company and will switch to lighter cigarettes";
4) Action: "I finally quit smoking."
5) Maintenance: "I have not smoked for two months."

These people, however, often return to the belief that they will continue to smoke (the so-called revolving door pattern). The Stages of Change model is used both in research and as a basis for therapeutic interventions that are tailored to the stage of a particular patient. For example, a smoker in the preparation stage will need a different type of intervention than someone who is still in the contemplation stage.

However, the model has been criticised for the following reasons, among others.

- It is difficult to determine whether behavioural change occurs in stages or as a continuous process. Researchers emphasise the difference between patterns that do not fit the stages of change model and those that do.
- The absence of qualitative differences between stages may be due to the stages being absent, or to them having been incorrectly measured and named.
- Changes between stages can occur so rapidly that the existence of stages becomes irrelevant.

- Therapeutic interventions based on the stages of change model may work because the person believes they are receiving special attention rather than because the model itself is effective.
- The concept of a 'stage' is complex as it encompasses many variables, such as current behaviour, attempts to quit a particular behaviour, intention to change and time since successful quitting.

The purpose of the article is to conceptualise the results of the theoretical analysis of the problem of attributional styles in understanding health.

Results and Discussion

Media campaigns that promote healthy behaviour and prevent unhealthy behaviour have become one of the main tools used by public health professionals to achieve better results in their work. Significant amounts of money, time and effort are invested each year in media campaigns at national and local levels to encourage citizens to eat healthily, exercise regularly, stop smoking and avoid alcohol abuse and unsafe sex.

However, research shows that the success of these campaigns can vary considerably and that their effectiveness is often difficult to measure (Hornik, 2002). Media campaigns can be described most simply as a form of information control, i.e. they usually aim to influence trends in the amount of information available on a particular topic. This influence can take two forms. The first form is an attempt to increase the amount of information available on a particular topic. For instance, a campaign to promote preventive mammography would aim to provide community members with more information than is already publicly available.

The second form of influence involves campaigners trying to increase the amount of information available on a particular topic (e.g. the number of newspaper articles, advertisements, leaflets and handouts) and clearly defining and framing the topic as an important public health issue. This makes the topic more visible, attracts the attention of the target audience and offers solutions to the problem (Perloff, 2002). In the case of mammography, for example, campaigners can draw women's attention to the prevalence of breast cancer and explain how early detection through screening can save lives. A successful media campaign will therefore satisfy both criteria, leading to quantitative and qualitative changes in the public's information environment regarding an important topic.

A review of recent media campaigns aimed at improving public health enables us to identify factors or conditions that determine a campaign's success. However, most experienced campaigners understand that these factors/conditions do not simply appear in the information environment, and therefore seek to influence the environment to improve these factors/conditions and ensure the success of the campaign. The overarching objective of most public health media campaigns is to change the behaviour of the population to prevent the spread of chronic diseases, and successful change in the information environment is the main goal.

Campaigns have traditionally been seen by both organisers and target audiences as time-limited initiatives focused on a narrow range of issues or concerns; campaign planning is necessarily focused on citizens and how to change their attitudes and behaviour with the "right messages". Significant amounts of time, effort and money are then spent on delivering these "right messages" as many times as possible to the widest possible range of the "right" target audience. This approach implies the first condition that, in our opinion,

must be fulfilled for a successful media campaign: successful manipulation of the information environment by the campaign organisers to ensure that the campaign messages and topics have sufficient impact on the target audience (maximising impact).

Other conditions include:

- use of marketing tools to create and further adapt relevant campaign messages (creative marketing and messaging);
- creating the accompanying structural conditions, such as an enabling environment/opportunity structure, that would allow the target audience to make the recommended change (enabling environment).

In addition to these basic criteria, additional aspects of the success of modern media campaigns should be emphasised, including:

- designing campaigns with a thorough understanding of the health behavioural factors that can potentially lead to the desired outcomes;
- analysis of campaign processes, including measurement and evaluation of exposure to campaign messages, can serve as useful intermediate markers both for making adjustments during the campaign and for explaining the final results (process analysis and evaluation of exposure). Successful manipulation of the information environment on a particular topic or issue is the main task of the organisers and sponsors of any media campaign.

The main media messages of the campaign are often complemented by other approaches, such as the distribution of educational printed materials or the creation of a news stream on the campaign topic, especially if budgets for buying airtime or media space are limited.

Past and present public health media campaigns are often under-resourced and dependent on television and radio broadcasters to provide time for public service announcements, which in turn affects the success of such campaigns. Studies have shown (Perloff, 2002) that overconfidence of campaign organisers in PSAs often leads to the fact that the main messages of the campaign are shown at less than optimal times, which worsens the structure and dynamics of contacts with the target audience. Due to the lack of additional funds, organisers of public health campaigns are often limited by the time/space allocated for social advertising by law, but they often supplement such campaigns with other strategies.

To complement and reinforce the key messages of the campaign, such complementary strategies may include the use of print materials such as newspaper and magazine ads, educational and informational materials such as brochures or leaflets, large format media such as billboards or posters, and branded promotional products such as T-shirts, caps, pens or calendars.

Another criterion for a successful media campaign is the existence of a supportive environment that enables individuals to make the health behavioural changes called for by the campaign. In our view, the success of a mass media campaign in promoting favourable behavioural change depends, among other things, on the nature of the environment that promotes change and the structural changes that accompany such campaigns. The relationship between structural change and mass media coverage, including mass media campaigns, is reciprocal. Media attention can strengthen the supportive environment, build public support, and give greater public legitimacy to changes in certain government or local public health policies (Siegel, 2002). Structural changes also act as long-term compensators after the campaign is over, as they last much longer.

In addition to using traditional mass communication channels such as local radio, television and newspapers to influence the environment, successful campaigns also try to

mobilise entire communities of people by engaging opinion leaders, NGOs and volunteer communities, charitable and educational initiatives. Alstead et al. (1999) provide an example of a campaign targeting both individual behaviour and the community environment to promote condom use awareness among sexually active adolescents and increase condom availability in public health facilities, for-profit and non-profit institutions and organisations. Mobilisation strategies included meetings with local opinion leaders, the formation of local advisory groups in schools, universities, businesses and organisations, and the distribution of printed and electronic materials. The campaign was moderately successful, with a significant increase in exposure to the campaign messages, but very little increase in condom use.

Conclusions

Some researchers have noted that public mobilisation alone can be an effective strategy for behaviour change. For example, studies of cervical cancer diagnosis have found that the most effective strategies combined mass media campaigns with additional therapeutic interventions. Black, Yamada, and Mann (2002) emphasise that public health strategies where mass media campaigns were used in conjunction with direct prevention education of women and/or public health staff were the most successful. As Marcus and Crane (1998) emphasise, mass media campaigns to promote behavioural change work best when they remove or reduce barriers to accessing health services. Other campaigns have also used social mobilisation strategies to influence the information environment, including campaigns to change public attitudes towards domestic violence, change social norms about alcohol abuse among high school and university students, raise awareness of emergency contraception among young women, and so on. In general, it is worth noting that mass media campaigns combined with public mobilisation strategies are more effective than either component alone.

Creating a favourable environment for change is a key factor for successful behavioural change in both the short and long term. Based on a review of key theories of health behaviour, Fishbein et al. (2002) identified four main factors that potentially influence individual behavioural intentions and behaviours:

- the individual's perception of susceptibility to disease or infection;
- individual's attitudes towards certain forms of behaviour;
- behavioural norms, which in turn are influenced by the factors of the immediate group environment and the social environment in which the individual functions;
- self-efficacy, the individual's confidence in performing and maintaining certain behaviours.

Together and individually, these four factors can be potential targets of mass media campaigns aimed at achieving desired changes in individual and mass health behaviour.

Sometimes, organisers of public health campaigns explicitly refer to scientific theories that inform the key messages and strategy of the campaign. For example, some campaigns use social cognitive theory to encourage favourable changes in individual health behaviour. This theory emphasises the importance of individuals being confident that they will be able to follow the recommended behaviour, and that the costs of performing and maintaining this behaviour are outweighed by the benefits.

Jorgensen et al. used this theory to plan a campaign to encourage people aged 50 and over to consult a doctor about colorectal cancer screening. Similarly, Kelder et al. used CCT to develop a campaign plan to reduce substance use among adolescents and young adults (Kelder et al., 2000). This campaign aimed to alter adolescents' and young people's

perceptions, attitudes, and social norms regarding drug use, increase their individual and group resistance to drug use, and encourage them to make positive life choices. Prospects for further research are related to the empirical study of the psychological characteristics of attributional styles in relation to human health.

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