Fatalism and Health Behaviors: Exploring the Context for Clinician-Patient Interactions

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Abstract
As nurse scientists and clinicians working in healthcare, we are often seeking methods and models to encourage positive changes in lifestyle behaviors to help our patients become empowered to improve their health status. We are beginning to recognize that a phenomenon known as “fatalism” can influence perceptions of, and thus adherence or non-adherence to, healthy lifestyle behaviors. Experts have defined fatalism as a sense of lack of control and powerlessness over health and illness. Since fatalistic tendencies have been associated with perceived barriers to improved health status, the psychological management of fatalism is important for clinicians to address with patients. This work presents a practical, evidence-based set of principles and relevant examples for clinician-patient communication when fatalism is expressed by patients in healthcare settings. The set of principles is based on the basic tenets of Health Belief Model (HBM) and the reported functions indicating the different ways persons manage fatalistic tendencies from a psychological perspective: a) Stress relief; b) Uncertainty management; c) Sense-making; and, less strongly d) Face-saving. The set of principles is intended to support clinicians in context of active listening and open communication with patients. Supporting patients in moving from feeling powerless to powerful regarding their own health behaviors promotes the potentially positive influence of fatalism when discussion of risk reduction occurs. Fatalism is ultimately viewed by some experts as a potential “motivator” of positive behavioral change when assessed in context in relation to the patient’s intellectual and emotional responses to the diagnosis and treatment plan.

ABBREVIATIONS
HBM: Health Belief Model

INTRODUCTION
As nurse scientists and clinicians working in healthcare, we are often seeking out methods and models to encourage positive changes in lifestyle behaviors to help our patients and their families become empowered to improve their health status. Whether we focus on the Health Belief Model [1], perceived self-efficacy [2], or another evidence-based framework for promotion of positive behavioral changes in our patients, we must recognize that a phenomenon known as “fatalism” [3] can influence perceptions of, and thus adherence or non-adherence to, healthy lifestyle behaviors [4,5].

It benefits us as scholars to pause and reflect on a patient’s potential for fatalistic tendencies, and how these tendencies may subsequently impact patient health outcomes. This work presents a practical, evidence-based set of principles for clinician-patient communication when fatalism is expressed in the healthcare setting, based on current evidence and the basic tenets of the Health Belief Model [1]. Before these principles are discussed, it is important to review current evidence regarding how fatalism is reported to influence patient health behaviors.

BACKGROUND AND SIGNIFICANCE
Fatalism and Its Potential to Influence Health Outcomes
Fatalism has been defined as “a sense of lack of control and powerlessness over health and illness.” [5] Concepts related to the phenomenon known as fatalism are reported to be predetermination, pessimism and luck [5]. Examples of questions that a person with fatalistic tendencies or beliefs would be likely to respond positively to include, “If someone is meant to get a serious disease, they will get it no matter what they do”; “My health is a matter of luck; and “I often feel helpless when dealing with the problems of life [1,3].”

A 20-item health fatalism scale was recently developed by Shen and colleagues [3] and tested by others to confirm the scale’s validity and reliability. The scale is disease-specific, but it can easily be adapted to different health conditions based on the proposed project or targeted population(s), when utilizing it to...
A recent study of fatalism conducted by Mudd-Martin and colleagues [5] in rural Kentucky, USA, demonstrated how important the assessment of fatalism can be in the context of evaluation of healthy lifestyle behaviors based on family history. In their study, 1027 rural participants were assessed for levels of fatalism in relation to their family history and risk for cardiovascular disease (CVD) [5].

Interestingly, one might expect high levels of fatalism would lead to low levels of treatment compliance in any setting; however, in the rural Kentucky study, a high risk family history of CVD combined with a high level (75th percentile) of self-reported fatalism predicted better adherence to healthy lifestyle behaviors [5]. In contrast, results of the study also revealed that among participants with low and moderate levels of self-reported fatalism, “no significant differences in behaviors were found between those with high-risk and average-risk family history [5].” Thus, knowledge of high risk factors and significant family history may combine to make fatalism a protective motivating factor for engagement in healthy lifestyle behaviors [1,3,5].

Distinctions surrounding gender and socioeconomic status were also reported to be present in regard to levels of fatalism in the rural Kentucky study. Women with low levels of fatalism adhered less to healthy behaviors compared to male participants [5]. These results are similar to other recent studies wherein women are reported to be less physically active [6,7] and have higher rates of obesity than men, especially in lower socioeconomic populations [8,9]. Perhaps not surprisingly, in the Kentucky, USA study, higher socioeconomic status was positively associated with adherence to healthy behaviors, and higher cholesterol and BMI levels were negatively correlated to healthy behaviors [5].

Age has also been reported to play a role in healthy lifestyle behaviors, with Mudd-Martin and colleagues [5] reporting increasing age as a significant predictor of healthy lifestyle behaviors, regardless of self-reported level of fatalism [5]. While fatalism was reported to moderate the association between family history and participants’ health behaviors in the rural Kentucky study [5], being diagnosed with a chronic illness, which often occurs as we age, became a “protective” motivating factor, in that these personal experiences are reported to predict higher levels of healthy behaviors [5,10,11]. Similarly, Newson et al. recently reported that onset of chronic illness spurred positive behavioral changes later in life [10].

Theoretical Underpinnings for Clinician-Patient Communication

As we ponder the concept of fatalism and how it may influence patients’ lifestyle behaviors, can strong feelings of powerlessness eventually, and ironically, encourage our patients to be more diligent in adhering to their recommended treatment regimen? Moreover, intuitively, do our patients’ often learn from their feelings of powerlessness as they simultaneously exhibit fatalistic tendencies, as some recent studies have demonstrated? What set of principles can we use to help guide us when we encounter fatalism in our patients?

To support a practical, evidence-based set of principles and relevant examples for clinician-patient communication when fatalism is expressed in the healthcare setting, the basic tenets of the Health Belief Model (HBM) [1] and self-efficacy [2], need to be considered. According to HBM, patients will engage in healthy behavior (s) if they perceive that the benefits of the behavior (s) are greater than the perceived barriers, and if they believe in their actual ability to engage in the behavior (s) [1]. In addition, the concept of self-efficacy is a foundational concept of HBM. A person’s beliefs regarding positive perceptions of self-efficacy means that an individual believes in their ability to address and manage an issue in their life successfully [2].

Since having a high-risk family history enhances perceived susceptibility to a disease [12], and fatalistic tendencies have been associated with perceived barriers to improved health status [13], each of these two elements mentioned, health risk and fatalism, must be ascertained by the clinician in the context of active listening and open communication with patients in their care. Therefore, to support the development of two relevant communication principles concerning 1) aspects of patient’s risk assessment and 2) psychological management of fatalistic tendencies, the tenets of the HBM and the concept of self-efficacy [2] are considered in step-wise fashion, based on evidence regarding fatalistic tendencies previously discussed.

First, a thorough family history and risk assessment must be conducted by the clinician, as HBM proposes that the individual will be more likely to engage in healthy behaviors if the benefits of such behaviors are viewed as manageable compared to any barriers [1]. Therefore, thoughtful risk reduction planning based on current evidence, with the clinician focusing the discussion on the patient and their potential ability to engage in self-care management, has been emphasized as an integral part of each of the aforementioned studies of patients’ fatalistic tendencies [3,5,9-12]. Moreover, discussion of the patient’s self-reported ability to engage in self-care management is extremely important, as it would also help the clinician discern the patient’s perception of self-efficacy regarding the physical and psychosocial aspects of their current diagnosis (es) [2].

Secondly, since fatalistic tendencies have been associated as a patient’s perceived barrier to improved health status [13], as well as a patient’s potential motivator to engage in healthy behaviors, the clinician can apply tenets of both HBM [1] and self-efficacy [2] by communicating an emphasis on engaging in health behaviors that the patient can control. Therefore, this type of clinician-patient discussion acknowledges the current reality of the individual’s specific situation, while supporting beliefs in one’s ability to place “mind over matter” to overcome perceived barriers to self-efficacy [2] by choosing to take control. The following sets of principles are presented with communication examples in an effort to illustrate the two major elements that the clinician can address when fatalistic tendencies are observed.

DISCUSSION

Communication Principles for Fatalism

Risk Assessment and Risk Reduction Plan: First, the clinician intuits from current evidence that, even when
healthcare resources are limited, a thorough family history and risk assessment, along with the co-creation of a personalized risk-reduction plan with the patient, takes on a renewed focus in the clinical setting. Whether a visit is completed “virtually” via tele-health technologies or in-person in the clinic or office, the clinician should take into consideration any fatalistic language or statements that may present themselves regarding diagnosis and treatment, thus acknowledging the potential influence (either positive or negative) of fatalism on the patient’s health outcomes [4,5].

Therapeutic Communication: Secondly, experts tell us that in any situations involving promotion of healthy behavioral change (s), health communication should be a planned, therapeutic process [1,14,15]. To increase a clinician’s understanding of the patient’s perceptions of a situation, the basic elements of therapeutic communication involve active listening, reflecting and repeating back what is being said to be certain you are understanding the patient; sharing observations, acknowledging feelings, and suggesting collaboration to support them in meeting treatment goals [15]. These aspects of therapeutic communication combined with providing factual information, help to guide the clinician in consideration of the health communication examples reflecting the different types of fatalism (see below) [14,15]. In contrast, communication strategies the clinician should avoid include reassuring clichés (“Everything will be alright”), expressing approval or disapproval (“I agree with you”/”You shouldn’t do that”), belittling feelings (“I know exactly how you feel”) or becoming defensive (“I am quite capable of charting your treatment plan”) [15]. Promoting open, therapeutic communication and avoiding these latter communication pitfalls allows the clinician and patient to engage in a true, collaborative dialogue that can reveal the most doable therapeutic process [1,14,15]. To increase a clinician’s communication example. In any case, experienced clinicians encourage active listening and open discussion with patients and their families in all situations involving fatalism [4,10,13-15], and consultation with faith-based experts and advocates is recommended to enhance the clinician’s cultural awareness and competence as needed when addressing situations specifically involving religious fatalism [16,17].

a. Stress relief: “What’s going to happen is going to happen; I am not going to worry a lot about it.” This type of response may indicate that the person accepts their condition(s), thus attempting to avoid excessive worrying or angst regarding their condition or diagnosis. The patient is trying not to worry about things they believe are out of their control [14].

b. Uncertainty management: “This runs in my family, not much I can do about that.” This type of response indicates that the person understands that there is not complete control over one’s health status, due to the influence of genetics and/or the environment [14].

c. Sense-making: “What’s done is done, I don’t know if quitting smoking will really ward off the cancer.” This response indicates that the person is trying to understand the consequences of their own past behaviors. The person may be ambivalent as to whether a behavior change now can still help them improve their health status [14].

d. Clinician response: The clinician can listen empathetically and emphasize any and all behavior changes that may help to improve the patient’s health status in the future, while acknowledging reality when uncontrollable factors are also influencing the patient’s health status.

Psychological Management of Fatalism: Thirdly, if fatalistic tendencies are observed, Keeley and colleagues [14] have suggested the following functions to indicate the different ways persons manage these tendencies from a psychological perspective: a) Stress relief; b) Uncertainty management; c) Sense-making; and, less strongly d) Face-saving. Paradoxically, across 96 interviews and 1832 pages of transcripts, the authors reported that the participants in this qualitative study always mentioned the potential for a positive behavioral change anytime they made a fatalistic statement regarding their own or someone else’s health status [14]. This fatalistic-optimistic polarity underscored one of the authors’ major conclusions: “This consistent co-occurrence of fatalistic talk, and statements endorsing behavioral change, suggests that fatalistic talk should indicate that the participant does not believe that health behaviors are in effective [14].” “Taking these results into account, the aforementioned 4 functions that are reported to serve as a person’s psychological management of fatalistic feelings are defined below, with evidence-based suggestions for patient-provider communication for the clinician to consider, based on which type of psychological function is observed with the patient.

Note that fatalistic statements from a religious point of view such as “This is God’s will” may fall into any of the fatalism categories below [14]. Thus, an example specific to religious fatalism is also provided in “sense-making,” the third communication example. In any case, experienced clinicians encourage active listening and open discussion with patients and their families in all situations involving fatalism [4,10,13-15], and consultation with faith-based experts and advocates is recommended to enhance the clinician’s cultural awareness and competence as needed when addressing situations specifically involving religious fatalism [16,17].

i. [Religious] Sense-making: “it’s God’s will that I am sick.” This response indicates that the person believes, based on their faith, that their illness is part of God’s plan for them [16,17]. As above, the person is ambivalent as to whether a behavior change now could still help them improve their health status because of their religious beliefs that God is in control, and/or they may state that they believe they are being punished as a consequence of their past behavior(s) [16,17].

ii. [Religious] Clinician response: The clinician can listen empathetically and ask open-ended questions to learn more about their patient’s particular religious beliefs [15-17]. Sharing observations that reflect the importance of behavioral change
to maintain or improve one’s health can be incorporated and discussed, along with the knowledge of the same or a similar faith community that is involved in health promotion, intervention and education in the community [16,17]. Recent studies have revealed that certain faiths may actually be contributing to members’ positive health attitudes and behaviors [16,17].

**d. Face-saving: “It is not my fault that I am sick, this could have happened to anyone in my situation.”** This response indicates that the person is avoiding self-blame for their own health status to save face, and that they perceive instead that being diagnosed with an illness is a random occurrence [14].

**a. Clinician response:** The clinician can discuss the patient’s health status and treatment plan in a therapeutic, nonjudgmental manner, while still being realistic regarding any behavior changes that are needed as part of the treatment plan [15]. The clinician also understands that especially in cases of lower socioeconomic status, adequate and targeted community resources may be the main pathway to removing the conditions in which fatalistic statements emphasizing randomness tend to occur [14].

**CONCLUSION**

As Keeley and colleagues point out about their study of fatalism, “These findings support a model of human mental processes that holds that people have accessible a variety of non-consistent beliefs that they may strategically deploy in different contexts….If fatalism serves an important function for people, then removing fatalistic beliefs may sometimes be counterproductive to people’s health” [14]. “Indeed, as these authors point out, fatalistic beliefs almost always co-occur with positive perceptions of one’s efficacy and ability to engage in behavioral change [14]. Moreover, more recent studies of religious fatalism have revealed that in spite of feelings of conditions being under God’s control, a greater number of faith-based organizations are emphasizing, and even sponsoring, healthy lifestyle behavior activities and programs [16,17].

Recent research supports, and several healthcare experts suggest, that clinicians need to consistently include an emphasis on family history education as part of the risk-reduction patient education plan in primary practice. Supporting patients in moving from feeling powerless to powerful regarding their own health behaviors promotes the potentially positive influence of fatalism when discussion of risk reduction and family history occur. Thus, fatalism can be viewed as a potential “motivator” of positive behavioral change when assessed in context with the patient in relation to their intellectual and emotional responses to the diagnosis and treatment plan.

The set of principles presented here supports a practical, evidence-based approach to fatalistic tendencies when they arise, promoting the discerning management of fatalism to empower patients improve their health status. Since fatalism may ultimately motivate the patient to engage in positive health behavior, perhaps “seeing is believing” and ultimately driving certain health behaviors, for many patients in our care.

**REFERENCES**


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