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"There's a higher power, but He gave us a free will": Socioeconomic status and the intersection of agency and fatalism in infertility

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ABSTRACT

Existing literature characterizes fatalism as a passive reaction to health in the face of powerlessness and constructs agency as a more activist perspective based in self-efficacy and control. Frequently studied together, researchers extol agency as the appropriate approach to decision-making around health, while discouraging fatalistic outlooks. Despite associating such beliefs with social classes—agency with high socioeconomic status (SES) groups and fatalism with low SES groups—there is little research that compares health beliefs across class groups. By examining the medicalized condition of infertility among women of both high and low SES, this study examines *how* social class shapes reactions to health and illness. Through 58 in-depth interviews with infertile women in the U.S., we reveal the complexity of fatalism and agency and the reasons behind that complexity. We first examine the commonalities among SES groups and their mutual use of fatalism. We then demonstrate the nuance and continuity between the health beliefs themselves—fatalism can be agentic and agency can be achieved through fatalism. In other words, we disrupt the binary construction of health beliefs, their conflation with social class, and the static application of health beliefs as psychological attributes, ultimately exposing the classist basis of the concepts. Doing so can result in improved patient care and reduced health inequalities.

Researchers have associated fatalism, the belief that life circumstances are in the hands of a higher power (e.g., meant to be, due to fate, God-given), with poor health behaviors (see Finlayson et al., 2005; Peek and Sayad, 2008). For instance, Chavez et al. (1997) found that fatalistic women sought Pap smears about half as often as women with more agentic outlooks. Given findings such as these, it is easy to see why public health programs are designed to discourage fatalistic beliefs and encourage agency. Yet, are agency and fatalism mutually exclusive? Is one better than the other or is the way we have defined the beliefs based on mainstream cultural values that privilege self-efficacy over fate (Barrett and Wellings, 2002; Greil and McQuillan, 2010; Keeley et al., 2009)?

Recent research has begun to recognize the inherent complexity of health beliefs. For instance, Drew and Schoenberg (2011) claim that individuals operate on a continuum of health beliefs with fatalism and agency at either end of that continuum, but other, more complex and diverse beliefs, in between. Indeed, even within fatalism itself, Welch (2011) identified six different ways the belief is enacted and perceived.

Beyond recognizing this complexity, however, research has not explored how or why such beliefs exist. More specifically, it has not examined how those beliefs may vary by social class, which is especially important since class is frequently conflated with the fatalism/agency binary (Zadoroznyj, 1999). Researchers and popular stereotypes characterize poor and working-class individuals as fatalistic in orientation, while middle-class individuals are deemed to be more agentic (Blaxter, 1990; Zadoroznyj, 1999). There are few, if any, studies, however, that compare health beliefs *across* class groups. Most research focuses on one demographic group (e.g., poor African American women) which provides specific insight, but without comparison it cannot fully explain how social class shapes health beliefs or examine the influence of context (Bruce and Thornton, 2004; Egede and Bonadonna, 2003; Powe and Johnson, 1995). Moreover, limiting research to one marginalized group assumes that fatalism is absent among higher-class groups, which reinforces the binary and its division among classes. As Drew and Schoenberg (2011, p.166) argue, however, we must "move beyond a simplistic attachment to fatalism and consider instead the social and political economic contexts within which illness is experienced."

This paper is an attempt to fill these gaps in the literature. Utilizing a sociological lens and comparing across social classes, we explore how social class shapes reactions to health and illness. We

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do so through the case of infertility—a thoroughly medicalized and classed phenomenon. Comparing infertile women's experiences overturns traditional dichotomous notions of fatalism and agency and their basis in class attitudes.

In demonstrating these effects, we first more explicitly review the current literature on fatalism and the medicalization of infertility. Second, by comparing how women of high and low socioeconomic status (SES) respond to their infertility, we explore the inherent complexity of fatalism and agency and how women differentially, and many times simultaneously, utilize those beliefs depending on their needs and desires.

1. Health beliefs: the social construction of agency & fatalism

Fatalism is typically defined as a passive reaction to health in the face of powerlessness, while agency is considered a more activist perspective based in self-efficacy and control (Drew and Schoenberg, 2011; Ross et al., 1983). For years, research approaches treated these reactions as stable health beliefs among groups—such beliefs would be "deployed regardless of context" (Keeley et al., 2009, p.744). Put simply, fatalism and agency were thought to be individual, fixed attitudes (Drew and Schoenberg, 2011).

Because of researchers' inattention to social context, correlations between lower socioeconomic groups and fatalistic health behaviors created a generalized and oversimplified narrative about class and fatalism: fatalism was thought of as a fixed and even inherent characteristic of low SES groups, while agency was linked exclusively to those of high SES (Lee et al., 2012; Zadoroznyj, 1999). Rather than explore how different SES settings conversely shape opportunities and barriers to enact such beliefs, research employed a "culture of poverty" framework in which individuals were considered responsible for the values and attitudes they projected (Drew and Schoenberg, 2011).

This framework projected health beliefs as moral attributes. Western mainstream culture values autonomy, independence, and control, which counter the definition of fatalism as a passive and powerless reaction to health (Bruce and Thornton, 2004). In turn, individuals enacting fatalistic beliefs are often inaccurately perceived as ignorant and irrational, while agency is a privileged viewpoint delineating rational behavior (Davison et al., 1992; Straughan and Seow, 1998). These assigned judgments are reflected in health education programs in which their goal is to discourage fatalism and encourage active health behaviors and beliefs (Balshem, 1990). Such programs disregard the potential advantages fatalism may provide and assume apathy among those who enact it. But, what if fatalism is actually advantageous to one's health? What if individuals rationally 'choose' fatalistic behaviors due to their specific circumstances?

Recent research has begun to demonstrate the functionality of fatalism. Moreover, it has shown how fatalism is a rational response to an individual's circumstance. Keeley et al. (2009) study reveals how poor and minority populations do not have "deficient belief systems," but have elevated levels of fatalism due to more uncertainty and stress in their lives (p. 745). Marginalized individuals do not have the ability or access to control over their health that is present in higher SES settings. Being fatalistic, however, is not necessarily disadvantageous (Bolam et al., 2003). Indeed, Keeley et al. (2009) show that it is a way to avoid self-blame and elude stress. In other words, "fatalism is not a global belief that functions the same in every context, but rather it serves specific functions in specific contexts" (Keeley et al., 2009, p.736).

Despite these findings, the majority of literature examining health beliefs tends to ignore context. With a public health perspective rather than a sociological lens, studies examine, for example, the likelihood of receiving preventive health care according to the fatalistic orientation of individuals (e.g., Dettenborn et al., 2005). While these studies shed light on the significance of health beliefs in shaping well-being, their designs prevent in-depth examination of how those beliefs are based in social circumstances. The dependence on survey instruments to capture fatalism abstracts the concept from its context and assumes that it is "a global, stable belief," defined the same way for everyone (Keeley et al., 2009, p.736).

But, is fatalism the same for everyone? Past research has been unable to explore such a question due to its lack of qualitative comparison across sociodemographic groups. Examining fatalism among a single group, typically one that is marginalized, replicates the stereotype that fatalism is a belief predominant among such groups, reifying their conflation (Bruce and Thornton, 2004). It also masks the nuance and construction of health beliefs. For example, how might the functions of fatalism, as outlined by Keeley et al. (2009), be different by social class? What is it about context that constructs those behaviors? Research has focused on the effects of fatalism and agency without problematizing the actual construction of the terms themselves.

2. The intersection of medicine & class: the social construction of infertility

Just as agency and fatalism are constructed along class lines, so, too, is infertility. Approximately one in eight women in the U.S. experience infertility or childbearing difficulties at some point in their lives (Chandra et al., 2013a, 2013b). Despite this high prevalence, infertility is stereotyped as primarily affecting one type of woman—a woman who is white and wealthy (Culley, 2009; Greil et al., 2011). But, in reality, poor women and women of color have higher rates of infertility because of class- and race-specific disparities, such as a higher prevalence of sexually transmitted infections and less access to reproductive health care among their populations (Chandra et al., 2013a, 2013b). Their stories of infertility are silenced, however, due to dominant ideologies around motherhood and reproduction. Poor women of color are constructed as excessively fertile and unfit to mother, whereas middle- and upper-class white women inform the basis of 'good' motherhood and are considered not fertile enough (Greil et al., 2011). Thus, marginalized women are placed outside the bounds of infertility, rendering them invisible in its discourse.

These class- and race-based representations inform public policy and practice around infertility. In particular, the medicalization of infertility, or its treatment as an illness rather than a social construction or natural part of life, is based in such images (Greil et al., 2011). For example, infertility treatment is allocated along dominant race and class divides with nearly ninety percent of infertility treatment in the U.S. being prescribed to white, college educated women (Chandra et al., 2013a, 2013b; Jain and Hornstein, 2005). Moreover, medicine naturalizes constructions of infertility and reproduction through its focus on the body (Franklin, 2013). The medicalization of infertility constructs it as an embodied, 'objective' experience rather than a social phenomenon. Doing so diminishes the social construction of infertility as well as the contextual diversity within experiences of infertility.

Past research has perpetuated the medicalized, stereotypical understandings of infertility. While there have been cross-cultural studies on infertility (e.g., Inhorn & van Balen, 2002), most studies recruit participants from medical clinics, resulting in samples composed primarily of white women of high SES (Greil et al., 2010). Little is known about how women with less income perceive and experience infertility. If infertility has not been