

# Advance Care Planning: Understanding Attitudes

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## Introduction to Advance Care Planning (ACP)

Advance Care Planning (ACP) represents a crucial process in healthcare that allows individuals to define their values, express their preferences regarding future medical treatment, and designate a healthcare proxy or surrogate decision-maker, should they become unable to communicate those decisions themselves. Fundamentally, ACP is not merely the completion of a legal document, such as an Advance Directive, but rather an ongoing series of conversations between the individual, their family, and healthcare providers. The primary goal of ACP is to enhance patient autonomy, reduce decisional conflict among family members, and ensure that the care received aligns with the patient's personal goals for quality of life, especially toward the end of life. Understanding **Advance Care Planning Attitudes** is paramount, as these attitudes--the deeply held beliefs, emotional responses, and readiness to engage--are the psychological precursors that determine whether an individual initiates, completes, and periodically reviews their planning process. Without a positive or receptive attitude toward confronting mortality and making future healthcare choices, the practical implementation of ACP often stalls.

The distinction between the process of ACP and the documentation of Advance Directives is critical for understanding associated attitudes. ACP is the dynamic process of reflection and communication, while an Advance Directive (AD) is the static legal instrument that records those decisions. Attitudes toward ACP encompass readiness to discuss death, comfort with uncertainty, trust in the healthcare system, and the perceived utility of the planning exercise itself. Conversely, attitudes toward the AD might focus more narrowly on the legality, enforceability, or perceived rigidity of the document. Research consistently demonstrates that individuals who hold positive attitudes about the benefits of preparation and communication are significantly more likely to engage in the process, regardless of their current health status. These positive attitudes act as a motivational gateway, transforming abstract concepts of future illness into concrete steps for preparation, thereby mitigating the psychological inertia often associated with end-of-life discussions.

The formal tone required for a psychology encyclopedia entry necessitates a rigorous examination of the psychological underpinnings of these attitudes. ACP attitudes are complex, drawing upon cognitive factors (knowledge about medical interventions), affective factors (fear, anxiety, denial), and behavioral intention (readiness to act). A favorable ACP attitude is characterized by a belief in the efficacy of planning--that discussing preferences now will lead to better outcomes later--and a high degree of perceived self-efficacy regarding one's ability to articulate those wishes clearly. Conversely, negative attitudes are frequently rooted in mortality salience, cultural taboos surrounding death, or a profound lack of trust in the medical establishment. Therefore, effective promotion of ACP requires interventions that do not just provide information, but actively address and reshape these underlying emotional and cognitive attitudes, moving individuals from avoidance or contemplation into active preparation.

## The Psychological Significance of ACP Attitudes

The psychological significance of ACP attitudes stems directly from established models of health behavior, such as the Theory of Planned Behavior (TPB), which posits that behavioral intention is the most immediate predictor of actual behavior, and that intention is, in turn, shaped by attitudes toward the behavior, subjective norms, and perceived behavioral control. In the context of ACP, a positive attitude is defined by the belief that ACP is beneficial, worthwhile, and personally relevant. If an individual views ACP as an inherently morbid or futile exercise, their intention to engage will be low, regardless of external pressures or opportunities. The psychological hurdle inherent in ACP is the necessity of confronting one's own finitude, a challenge often met with powerful defense mechanisms, most prominently denial and emotional avoidance. These defense mechanisms serve to protect the ego from anxiety related to mortality, but simultaneously obstruct the rational consideration required for effective planning.

Mortality salience, the awareness that death is inevitable, plays a dual role in shaping ACP attitudes. While the awareness of mortality is the very reason ACP exists, high levels of mortality anxiety can paradoxically lead to avoidance, consistent with Terror Management Theory (TMT). When individuals are overwhelmed by the threat of death, they may cling more strongly to cultural or religious beliefs that offer symbolic immortality, or simply refuse to acknowledge the immediacy of the threat, thereby rejecting the utility of ACP. However, when mortality is framed not as an imminent threat but as a manageable future event, ACP attitudes can shift positively. Effective psychological framing focuses on ACP as an act of **responsibility and love** toward one's family, rather than a surrender to death. This cognitive restructuring helps individuals reframe the process from a fear-inducing task to an empowering mechanism for maintaining control and protecting loved ones from difficult choices.

Furthermore, perceived control and self-efficacy are critical psychological components that underpin positive ACP attitudes. Individuals who believe they have the capacity to understand complex medical information and effectively communicate their wishes exhibit higher self-efficacy concerning ACP. This sense of control is highly protective against the feelings of helplessness that often accompany serious illness. Conversely, low self-efficacy--the belief that one cannot successfully complete the planning process or that their wishes will ultimately be ignored by the healthcare system--is a significant negative predictor of engagement. Successful interventions aimed at fostering positive attitudes must therefore focus on building this sense of control, often through step-by-step guidance, clear educational materials, and the use of trained facilitators who can demystify the medical and legal complexities. The emotional labor involved in ACP is substantial, and positive attitudes provide the necessary psychological resilience to undertake this labor.

## Conceptual Frameworks for Understanding ACP Engagement

To systematically address and modify ACP attitudes, researchers frequently employ established conceptual frameworks derived from health psychology. The Transtheoretical Model (TTM), or Stages of Change Model, is particularly useful for categorizing an individual's readiness to engage in ACP. This model views ACP engagement not as a single event, but as a progression through distinct stages: Precontemplation (unaware or unwilling to discuss), Contemplation (thinking about it but not yet committed), Preparation (ready to take action soon), Action (actively engaging in discussion and documentation), and Maintenance (reviewing and updating plans). An individual's specific attitude--whether one of avoidance, ambivalence, or readiness--is directly correlated with their current stage. For instance, a person in the Precontemplation stage exhibits attitudes dominated by denial or lack of perceived necessity, requiring motivational interviewing techniques to raise awareness, whereas a person in the Preparation stage holds attitudes emphasizing urgency and perceived benefit, requiring practical assistance to facilitate action.

The Health Belief Model (HBM) provides another robust framework for analyzing the cognitive components of ACP attitudes. HBM suggests that the likelihood of engaging in a health behavior depends on several core beliefs: **Perceived Susceptibility** (the belief that one is vulnerable to serious illness), **Perceived Severity** (the belief that the consequences of that illness are serious), **Perceived Benefits** (the belief that ACP will reduce the threat or improve outcomes), and **Perceived Barriers** (the costs, difficulties, or negative emotional aspects of engaging). Negative ACP attitudes often stem from low perceived susceptibility (e.g., "I'm healthy, this doesn't apply to me") or high perceived barriers (e.g., "It's too difficult to talk about," or "My doctor doesn't have time"). Interventions designed using the HBM must specifically target these cognitive elements; for example, by providing personalized risk assessments to increase perceived susceptibility, and offering structured, easy-to-use planning tools to reduce perceived barriers.

Beyond individual cognitive models, relational and systemic frameworks are essential, particularly those focusing on communication competence and trust. Attitudes toward ACP are heavily influenced by the patient's trust in their primary care physician and the healthcare system generally. If patients perceive that their providers lack the time, skill, or empathy to conduct meaningful ACP discussions, or if they harbor historical distrust (especially common in marginalized communities), their attitudes toward the entire process will be negative, regardless of their personal belief in its utility. Positive attitudes are fostered when patients experience open, empathic, and skillful communication from providers who normalize the conversation. This requires providers to possess high levels of communication self-efficacy regarding ACP, which, in turn, shapes their own professional attitudes toward integrating ACP into routine care, thereby creating a positive feedback loop that encourages patient engagement.

## Primary Barriers to Positive ACP Attitudes

A constellation of factors, both internal and external, contribute to the formation and maintenance of negative ACP attitudes, acting as significant barriers to engagement. Internally, the most powerful barrier is rooted in emotional avoidance, characterized by the psychological reluctance to engage in discussions about potential disability or death. This avoidance often manifests as procrastination, where individuals intellectually acknowledge the importance of ACP but continually postpone the action, believing there will always be a better or less stressful time to address it. Furthermore, many individuals harbor a fear of burdening their family with the emotional weight of the discussion, or conversely, fear that discussing their wishes will somehow hasten their own decline--a form of magical thinking common in mortality-related contexts. These deep-seated emotional barriers require sensitive, narrative-based interventions rather than purely informational approaches.

External and systemic barriers also profoundly shape negative ACP attitudes. A major obstacle is the lack of institutional standardization and support for ACP. If healthcare systems do not prioritize or allocate sufficient time and resources for comprehensive discussions, both patients and providers develop negative attitudes about the feasibility of ACP within the clinical setting. Patients often report that their physicians initiate ACP too late (only when prognosis is poor), or that the discussion is rushed and focused solely on legal documentation rather than values clarification. This leads to an attitude of skepticism regarding the true value of the process. Additionally, the lack of widespread public education means many people hold significant misconceptions about life-sustaining treatments (LSTs), such as the unrealistic expectation of positive outcomes from CPR or mechanical ventilation, leading to negative attitudes about limiting treatment options.

A frequently overlooked but potent barrier is the influence of family dynamics and subjective norms. While ACP is fundamentally an individual choice, the decision-making process is often relational. If an individual anticipates significant conflict with family members over treatment preferences, or if the prevailing family norm is to avoid discussions of death, the individual may adopt a negative or resistant attitude to maintain familial harmony. This is particularly true in cultures where healthcare decisions are traditionally made by consensus or by a designated family elder. Therefore, interventions must sometimes target the family unit's collective attitude, rather than just the individual patient, addressing fears related to guilt, responsibility, and the perceived abandonment of the patient if treatment is limited. Overcoming these barriers necessitates acknowledging that ACP attitudes are socio-psychological constructs, not merely medical facts.

## Facilitators and Interventions for Promoting ACP

Effective interventions designed to promote ACP and foster positive attitudes focus on reducing barriers, enhancing self-efficacy, and leveraging emotional and social facilitators. One highly

successful approach involves structured, standardized programs that utilize trained non-physician facilitators, such as nurses or social workers. These programs, like "Prepare for Your Care" or "Respect," provide a systematic, step-by-step process for values clarification, encouraging the individual to reflect on what constitutes quality of life for them, rather than immediately focusing on specific medical treatments. By separating the emotional reflection from the complex medical details, these interventions reduce cognitive load and anxiety, thereby shifting attitudes from apprehension to empowerment. The use of patient-friendly tools, including video-based decision aids, has been shown to significantly improve knowledge, increase confidence, and foster a more positive attitude toward the utility of the planning process.

The timing and setting of the ACP discussion are crucial facilitators. Positive attitudes are more likely to develop when ACP is introduced proactively, well before a health crisis, ideally during routine preventative care visits or upon diagnosis of a chronic condition. Integrating ACP into wellness check-ups normalizes the discussion, framing it as a standard component of responsible adult life management, rather than an urgent response to impending death. Furthermore, discussions held outside the high-stress environment of the hospital--such as in community centers, religious institutions, or specialized outpatient clinics--tend to yield more thoughtful engagement and more positive attitudes, as they allow for greater psychological comfort and time for reflection. The goal of facilitation is to transform ACP from a reactive requirement into a proactive, voluntary choice rooted in personal responsibility.

Social and normative influences also serve as powerful facilitators. When community leaders, religious figures, or trusted peers openly endorse ACP, the subjective norm shifts, making engagement more socially acceptable and even desirable. Public health campaigns focused on normalizing discussions about death and dying can significantly influence population-level attitudes. For example, initiatives that highlight personal stories of families who benefited from ACP demonstrate the tangible advantages of preparation, countering the abstract fears associated with the process. Training physicians and other healthcare professionals to hold positive professional attitudes toward ACP--viewing it as a core competency and an ethical imperative--is equally vital. When providers demonstrate comfort and expertise, patients perceive the process as credible and valuable, reinforcing their own positive attitudes toward engagement.

## Measurement and Assessment of ACP Attitudes

The rigorous study of ACP attitudes necessitates reliable and valid measurement instruments capable of quantifying complex psychological constructs. Researchers must differentiate between measuring ACP **knowledge** (factual understanding of directives and treatments), **self-efficacy** (confidence in one's ability to complete ACP), and true **attitude** (emotional and cognitive evaluation of the value or importance of ACP). Attitude scales typically employ Likert-type responses to gauge agreement with statements concerning the perceived benefits, barriers, and

readiness to discuss end-of-life care. A key challenge in measurement is ensuring that scales are culturally sensitive and applicable across diverse populations, avoiding language or framing that might bias responses based on differing cultural norms regarding autonomy or family involvement.

Several established instruments are used to assess various facets of ACP attitudes. For instance, scales may measure the perceived utility of ACP (how helpful the process is believed to be), comfort level with discussing end-of-life topics, or decisional readiness. The use of scenarios or vignettes is common, allowing researchers to gauge attitudes toward hypothetical decisions (e.g., withdrawing life support) rather than simply asking abstract questions. Psychometric properties, including internal consistency (reliability) and construct validity (whether the scale measures what it intends to measure), are essential for ensuring the utility of these tools. For example, a scale designed to measure comfort must demonstrate that high scores correlate negatively with measures of mortality anxiety, thereby confirming its psychological relevance.

Despite advancements, measurement of ACP attitudes faces inherent challenges, primarily related to social desirability bias and the hypothetical nature of the assessment. Individuals may report more positive attitudes than they genuinely hold because they perceive ACP as the "right" thing to do socially or medically. Furthermore, expressed attitudes in a research survey--conducted while the person is healthy--may not accurately reflect the attitudes and intentions that emerge under the stress of actual severe illness. This gap between hypothetical attitude and real-world behavior necessitates the use of longitudinal studies that track changes in attitudes as health status declines, providing a more ecologically valid understanding of how psychological barriers and facilitators operate during critical decision points. Future research must focus on developing implicit measures of ACP attitudes that bypass conscious cognitive filtering.

## Cultural and Demographic Variations in ACP Attitudes

ACP attitudes are not universally uniform; they are profoundly influenced by demographic factors, socioeconomic status, and, most notably, cultural and ethnic background. Age is a significant predictor: younger adults often exhibit avoidance attitudes rooted in low perceived susceptibility, viewing ACP as irrelevant until old age, while older adults may hold attitudes that reflect greater acceptance of mortality but sometimes resist ACP due to fatalistic religious beliefs or the perceived futility of planning when near the end of life. Socioeconomic status and education level correlate strongly with positive attitudes and engagement, largely due to greater health literacy, better access to information, and stronger trust in institutional systems.

Cultural variations represent perhaps the most critical area of study in ACP attitudes. In many Western, individualistic cultures, ACP attitudes prioritize **individual autonomy** and self-determination. However, in many collectivist cultures, attitudes are centered on the family unit, where decisions are made communally, and the burden of knowledge regarding a poor prognosis

may be intentionally shielded from the patient. In these contexts, an intervention focused solely on individual preference may be perceived negatively, as disrespectful to family authority or contrary to the cultural norm of shared responsibility. For example, studies among certain Asian, Hispanic, and African American populations often reveal lower rates of AD completion, not necessarily due to negative attitudes toward preparedness, but due to differing attitudes toward who should hold the decision-making authority--often preferring a trusted family member over a written document.

Furthermore, historical and systemic inequities shape attitudes toward ACP among marginalized groups. African American and other minority communities often exhibit lower engagement rates and more negative attitudes toward ACP, frequently stemming from a justifiable historical distrust of the healthcare system, concerns about potential bias in treatment recommendations, or fear that limiting care will lead to inadequate care. Effective, culturally competent ACP must therefore tailor its approach, focusing on building trust, utilizing community leaders as facilitators, and shifting the attitude from one of fear and distrust to one of empowerment and advocacy, ensuring that the process respects varied spiritual beliefs and family structures. Failure to address these cultural nuances results in ACP models that reinforce existing health disparities.

## Clinical Implications and Future Directions

Understanding and addressing ACP attitudes holds profound clinical implications. Clinicians must recognize that a patient's attitude is the primary determinant of whether an ACP discussion will be successful. Simply providing a form is ineffective if the patient holds negative attitudes rooted in fear or denial. Clinical practice must shift toward an attitude-assessment model, utilizing brief screening tools to gauge readiness (e.g., TTM stage) before initiating complex discussions. For patients in the precontemplation stage, the clinical focus should be on motivational interviewing and gentle exploration of values, rather than immediate documentation, thereby matching the intervention to the patient's psychological state.

Future research must focus on the longitudinal stability and malleability of ACP attitudes. While current studies often assess attitudes at a single point in time, more insight is needed into how attitudes shift in response to critical health events, changes in family structure, or exposure to media narratives about end-of-life care. There is also a critical need for research into the impact of technology on attitude formation. Digital platforms and artificial intelligence (AI) tools are increasingly used to initiate ACP discussions; understanding whether these tools foster positive attitudes by reducing emotional confrontation or negative attitudes by impersonalizing the process is crucial for ethical development.

Ultimately, the goal of improving ACP attitudes aligns with the broader imperative of achieving health equity. Policy changes are required to support clinicians in dedicating time to these discussions, ensuring that ACP is reimbursed and integrated early into chronic disease

management protocols. By prioritizing the psychological and cultural factors that shape attitudes, healthcare systems can move beyond mere compliance with legal requirements and achieve the true promise of ACP: ensuring that every patient receives care that honors their deepest values and preferences, fostering an attitude of control and dignity throughout the entire lifespan.

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