

Part V

Lifespan, Gender
and Sociocultural Perspectives

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Sociocultural Aspects of Health and Illness

Ayse K. Uskul

Chapter Outline

This chapter will provide a summary of sociocultural differences observed in various aspects of health and illness, drawing on evidence from medical anthropology and health psychology. It will then introduce a theoretical framework borrowed from cultural psychology, one frequently adopted when examining cultural differences in areas such as social behaviour, cognition and emotion, but rarely implemented when examining cultural differences in the domain of health and illness. This will be followed by some recent research originating from the area of illness cognitions, health communication and coping (use of social support), which adopts this framework to understand cultural differences.

Key Concepts

Culture
Culture and health
communication
Culture and illness
representations
Culture and social support
Individualism–collectivism

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Introduction

The biomedical view of health, characterised by a focus on physical mechanisms and diseases and featuring a reductionist point of view which defines health as the absence of disease (e.g. Suls & Walston, 2003) has long been replaced by a view that emphasises the role played by sociocultural forces in the shaping of health (and illness) and related psychological experiences (Engel, 1977; Taylor, 1978). In 1948, the World Health Organization (WHO) defined health as ‘a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity’, calling attention to the complexity and multidimensionality of the concept. Adding *social well-being* to the definition opened the way to conceptualising the individual as a social being, part of a bigger entity than his/her own body. Later, WHO (World Health Organization, 1982) referred to the importance of sociocultural factors by endorsing the following view:

If actions are to be effective in the prevention of diseases and in the promotion of health and well-being, they must be based on an understanding of culture, tradition, beliefs and patterns of family interaction (p. 4).

This shift in the definition of health and the factors responsible for disease prevention and health promotion is mirrored in a shift in the study of health and illness in disciplines such as psychology which traditionally focused on the individual as the unit of analysis and the force primarily responsible for avoiding disease and promoting well-being. In more recent psychological approaches to health and illness, the individual is increasingly viewed as part of a larger network of forces significantly influenced by his/her sociocultural environment. This approach has clear implications for models used in health psychology such as social cognitive and behavioural models of health and health promotion.

Traditionally, medical anthropologists have displayed an interest in the role of sociocultural factors in health and illness. They have extensively examined how illness is conceptualised and treated differently across cultures (e.g. Helman, 1994; Kleinman, 1980). For their part, medical sociologists have been inter-

ested in the effects of larger societal structures or institutions, such as medical delivery systems, on health and illness (e.g. Bird *et al.*, 2000). Now, psychologists are asking research questions that incorporate sociocultural variables into health and illness, investigating them in groups from different sociocultural backgrounds. This is encouraging for the field of health psychology: cross-cultural work can help researchers test their theories and assumptions in different cultural environments and practitioners in the field can be equipped with the knowledge to interact with individuals of different cultural backgrounds, a much-needed skill in a globalising world.

Culture, Health and Illness

This section provides a brief overview of research conducted to examine cross-cultural differences or similarities in areas relevant to health psychology: the experience of different medical conditions such as menopause and pain, health-care seeking and doctor-patient relationship. While the literature on the role of sociocultural factors in health and illness is by no means limited to this list, the goal is to draw attention to the sociocultural nature of health and illness and to issues typically considered individually driven.

Culturally construed and experienced medical conditions: menopause and pain

Our sociocultural environments shape our psychology regarding health and illness – that is, how we think of, feel about and act upon our physical states. Perhaps more striking is that individuals’ (reported) physical experiences seem to also be shaped by their sociocultural environments. The experience of menopause is an example of how previously universally defined physical signs of a certain stage of the life cycle may actually vary, depending on cultural characteristics. For example, Lock (1986) observed that Japanese women view menopause as a natural life-cycle transition in which the biological marker of cessation of menstruation is not considered to be of great importance. The reporting of symptoms was also different in Japan than in the West. Japanese women reported fewer symptoms and symptoms such as hot flushes or

sudden perspiration were experienced very infrequently, whereas these were among the most commonly reported by Western women. Lock explains the general Japanese experience of menopause by referring to women's place in Japanese society and how menopause is viewed historically by both medical and lay persons.

Another sample of culturally shaped physical experiences comes from studies showing whether and when people complain of pain (Clark & Clark, 1980; Lipton & Marbach, 1984; Mechanic, 1963; Poliakoff, 1993; Zborowski, 1952, 1969; Zola, 1966). For example, Zborowski (1952) examined experience of pain among three groups of patients: Italian Americans, Jewish Americans and mainly Protestant 'Old Americans'. Both Jewish and Italian Americans tended to be more emotional in response to pain and to exaggerate their pain experience, leading some physicians to conclude that these groups had a lower threshold of pain. However, this emotional display, although similar in these two groups, was based on different attitudes towards pain. The Italians were mainly concerned with the immediacy of the pain experience, especially the pain sensation itself. They complained a great deal, drawing attention to their suffering by groaning, crying or moaning, but once they were given analgesics, they rapidly forgot their suffering and returned to their normal behaviour. The anxieties of the Italian patients centred on the effects of the experience upon their immediate situation, such as their occupation or economic situation. By contrast, Jewish patients were mainly concerned with the meaning and significance of the pain in relation to their health and welfare and eventually, the welfare of their families. Their anxieties were concentrated on the implications of the pain experience on the future. Old Americans also tended to be future-oriented, but unlike Jews, they were rather optimistic. When in pain, however, they tended to withdraw socially, while both Jews and Italians showed a preference for the social company of their relatives.

Zborowski (1952) points out that a cultural group's expectations and acceptance of pain as a 'normal' part of life will determine whether it is seen as a clinical problem which requires a clinical solution. For example, in Poland, labour pains are

both expected and accepted by women giving birth, while in the USA they are not accepted and analgesia is frequently demanded. How one reacts to pain-killers may differ as well. Not all cultures are equally willing to use 'pain-killing' medication. Poliakoff (1993) suggests that many Chinese people fear that such medication will give them a feeling of being out of control; thus, they are reluctant to use them. Moreover, some people may accept pain as their due. For instance, Hindus who believe they are facing death may wish to do so 'clear-headed' rather than sedated and that negative feelings, such as pain, may be attributed to wrongs that they have committed in the past (Poliakoff, 1993). As these examples demonstrate, cognitive, emotional and behavioural responses to pain depend on cultural experiences and learning.

Culture and health-care seeking

Extensive literature in the domain of health-care seeking reveals that those from different sociocultural backgrounds tend to differ in the extent to which they delay seeking medical help. For example, studies show that being a member of an ethnic minority group can add to delay (e.g. Bottorff *et al.*, 1998; Dibble *et al.*, 1997; Stein *et al.*, 1991; Vernon *et al.*, 1985; Vernon *et al.*, 1992). Black women tend to have more advanced breast cancer when detected and, as a consequence, have poorer survival rates than white women once the cancer is detected (Bain *et al.*, 1986; Long, 1993; Nemcek, 1990; Polednak, 1986; Shapiro *et al.*, 1982). Hispanic women also have later-staged tumours and decreased survival rates (e.g. Westbrook *et al.*, 1975; Samet *et al.*, 1988). A Canadian National Population Health Survey has revealed the importance of sociocultural background in breast cancer related detection strategies: Canadian women are less likely to have mammograms if they are single, have less education, are unemployed and are immigrants from South America, Central America, the Caribbean, Africa or Asia (Gentleman & Lee, 1997).

Cultural differences in delay in health-care seeking are attributed to a diverse set of factors, ranging from knowledge and beliefs regarding causes of the disease, associated symptoms, curability and consequences; to

trust in physicians (for a review on delay in seeking help for breast cancer symptoms see Uskul, 2001). Factors of a more sociocultural nature have also been considered. For example, in the realm of breast cancer, studies reveal that women's place in the society can shape their help-seeking behaviour by determining their priorities. In several studies, Chinese women indicate concern about potential or actual disruptions in carrying out their responsibilities in the event of breast cancer symptoms (Facione *et al.*, 2000; Lee *et al.*, 1996; Mo, 1992); in the end, these are factors influencing whether medical help is sought. Similarly, South-Asian societies focus on how women should act, how they should fulfil their responsibilities towards their families and how they should maintain their proper place in the community; these too may lead to their decision to put others first and delay engagement in health-care behaviours (e.g. Bhakta *et al.*, 1995; Bottorf *et al.*, 1998).

Culture and doctor-patient relationships

Some cultural norms heavily regulate gender relationships even in a health-care setting such as a hospital. Studies show that female members of some cultural groups may be reluctant to be examined by male physicians and even the anticipation of this happening may contribute to delays in or complete avoidance of health-care seeking (Facione *et al.*, 2000; Pillsbury, 1978; Uskul & Ahmad, 2003). In these cultural groups, being examined by a female physician can mitigate the embarrassment (Bhakta *et al.*, 1995). Some Asian women, although they had been in North America for a while and knew the language, indicated that they may choose to access traditional Chinese medicine because the traditional Chinese doctor examines the patient without asking her to take her clothes off (Facione *et al.*, 2000).

The physician-patient relationship might also prove difficult if one thinks that one's beliefs do not fit with the medical beliefs endorsed by physicians. Bhopal (1986), who has explored causal beliefs and illness among Punjabis, observes that South Asians who associate their symptoms with traditional or folk beliefs may be reluctant to seek medical advice because they perceive that health-care providers lack cultural sensitivity.

A Framework for Understanding Cultural Differences in Psychology of Health and Illness

Cross-cultural variations of a given psychological phenomenon are commonly attributed to *culture*. Because culture can be very broadly defined as a set of structures and institutions, values, traditions and ways of engaging with the social and non-social world that are transmitted across generations (e.g. Shweder & LeVine, 1984), the term lacks the conceptual specificity required for predictions of when and how culture shapes health and illness-related psychological experiences (Oyserman & Uskul, 2008). Therefore, psychologists have proposed features of cultures to be used as organising constructs (e.g. tight vs. loose cultures, Triandis, 1995; masculine vs. feminine, high vs. low power distance, high vs. low uncertainty avoidance cultures, Hofstede, 1980; survival vs. self-expression, Inglehart 1997). The most commonly used constructs to account for observed cultural differences and similarities in human psychology are *individualism* and *collectivism* (e.g. Hofstede, 1980; Kagitcibasi, 1997; Kashima, 2001; Oyserman *et al.*, 2002; Triandis, 1995). These constructs have been particularly useful in helping understand cultural differences as to how people view the self and relationships with social others. As argued below, these differences are important in understanding cultural differences in health and illness-related experiences.

In *individualistic* cultures, such as the United Kingdom or the United States, the dominant model of the self is an independent self characterised by self-defining attributes which serve to fulfil personal autonomy and self-expression (Hofstede, 1980; Kagitcibasi, 1994; Markus & Kitayama, 1991; Oyserman *et al.*, 2002; Schwartz, 1990; Triandis, 1995). People are seen as agentic and thus responsible for their own decisions and actions. Moreover, in cultures shaped by individualism, individuals favour promotion over prevention, focusing on the positive outcomes they hope to approach rather than the negative outcomes they hope to avoid (Elliot *et al.*, 2001; Lee *et al.*, 2000; Lockwood *et al.*, 2005). Relationships are

seen as freely chosen and easy to enter and exit (Adams, 2005; Adams & Plaut, 2003).

By contrast, in *collectivistic* cultures, such as many East Asian cultures, the dominant model is an interdependent self embedded within the social context and defined by social relations and memberships in groups (Markus & Kitayama, 1991; Shweder & Bourne, 1984; Triandis, 1995). People are seen as relational or communal and their decisions and actions as heavily influenced by social, mutual obligations and the fulfilment of in-group expectations (Hofstede, 1980; Kagitcibasi, 1994; Oyserman *et al.*, 2002; Schwartz, 1990; Triandis, 1995). In such cultures, individuals tend to be motivated to fit in with their group and maintain social harmony (Markus & Kitayama, 1991); they focus on their responsibilities and obligations while trying to avoid behaviours that might cause social disruptions or disappoint significant others (Heine *et al.*, 1999; Kitayama & Uchida, 2005; Markus & Kitayama, 1991). They favour prevention over promotion in their motivational strategies, focusing on the negative outcomes they hope to avoid rather than the positive outcomes they wish to approach (Elliot *et al.*, 2001; Lee *et al.*, 2000; Lockwood *et al.*, 2005). Relationships are seen as less voluntary and more difficult to leave (Adams, 2005).

These cultural differences in the views of the self and relationships have implications for how health and illness are experienced and acted upon. Individualism, on the one hand, is likely to make individuals focus on the physical body and wellness; thus, having a healthy body can be characterised as a goal within an individualistic frame. In literature focusing explicitly on American individualism, the health-individualism linkage is evident; sociologists Rose (1996) and Lock (1999) link the American cultural focus on wellness, avoidance of illness and improvement of health with the American cultural focus on self-actualisation and personal responsibility. And psychologists Crawford (1984) and Baumeister (1997) link Americans' desire to maintain their health with their desire to be autonomous individuals. Collectivism, on the other hand, is likely to posit illness as a to-be-avoided breakdown in one's abilities to carry out obligations (Uskul & Hynie, 2007; Uskul & Oyserman, *in press*). Having a healthy body can be characterised as a resource that facilitates fitting into the social order

within a collectivistic frame. Thus, for collectivists, the desire to avoid the negative social obligation consequences of ill-health is likely to matter.

Individualism–Collectivism, Health and Illness

Although the theoretical framework presented above has been extensively used to explain cultural differences with regard to social, cognitive and affective cultural differences in many domains of human psychology, its use has been somewhat limited in the area of psychology of health and illness. This section summarises the existing research which implicitly or explicitly uses an individualism–collectivism framework to cross-culturally test models of illness cognition, health communication and coping.

Culture and illness representations

According to the self-regulation model of illness cognition and behaviour (Leventhal *et al.*, 1984), illness representations are organised sets of beliefs regarding illness labels or diagnoses and associated symptoms (identity), the factors or conditions believed to have caused the illness (cause), the expected duration of the illness (timeline), the expected effects of an illness on physical, social and psychological well-being (consequences) and the extent to which the illness can be cured or controlled through treatment measures and behaviours (control/cure). Adopting this framework, one could hypothesise that different components of illness representations endorsed by individuals of collectivistic cultural backgrounds will likely include other factors in addition to or different from the individual or biological ones; these will be embedded in the larger network of forces of which individuals are part. What these forces are will depend on the nature of collectivism adopted in different cultures. A limited number of studies show that illness representations are highly linked with a culture's philosophical and spiritual orientations which shape individuals' connectedness with social others and the surrounding physical world.

In cultures that emphasise the separation of individuals from their social and physical environments,

physiological processes of illness are given greater weight and are typically seen as separate from the social and physical environments in which individuals are embedded (e.g. Landrine & Kolonoff, 2001). In cultures emphasising the connectedness of individuals with their social and physical environments, physiological processes of illness are given lesser weight and illness beliefs are shaped by holistic worldviews connecting relational, collective and physical forces. For example, Maori in New Zealand identify spiritual, mental, physical and family well-being as interrelated dimensions of health; they believe that a break down in one of these dimensions is likely to cause illness (Durie, 1994).

In India, metaphysical beliefs, that is, belief in Karma, God and spirits, are understood to be important determinants of many events in one's life, including illness and suffering (Kohli & Dalal, 1998). Karma holds that good and bad deeds accumulate through a series of lives and people face the consequences; physical suffering is typically attributed to one's misdeeds in this and/or previous lives. God is an external agent who controls reward and punishment, not always according to what one deserves. The belief in fate implies that all life events are predestined and one can do little to alter them. In studies with Indian patients, Kohli and Dalal (1998) show that belief in fate and God's will is negatively correlated with perceived controllability, implying that those who attribute their illness to fate and God's will perceive little control over the course of the illness. Patients who believe God's will to be the cause of their illness show greater perceived recovery; patients who perceive bodily weakness as the cause of their illness are less effective in dealing with the crisis and their psychological recovery is poor. As seen in these studies and others (e.g. Agrawal & Dalal, 1992; Dalal & Singh, 1992; Lau *et al.*, 1989) perceived causality can vary dramatically as a function of cultural features; the network of forces in which individuals are embedded can have a significant bearing on responses to illness.

A study by Westbrook *et al.* (1994) examines the causal attributions for mid-life deafness among Anglo, Chinese, German, Greek, Italian and Arabic communities and compares these attributions with biomedical explanations. They ask health practitioners from these cultures to give causes that they believe mem-

bers of their own cultural community will use to explain deafness. The predicted causes are the following: God's will, chance, stress and tension, temperament, poor health, upsetting event and evil eye. The most frequently mentioned causes differ between cultures, but more interestingly, all differ from the specialists' expectations.

Collectivism has been shown to be associated with an interpretation of ill-health in terms of social responsibility and desire to avoid the failure to properly fulfil social obligations (Uskul & Hynie, 2007). In a study involving recall of a time when one was ill, participants rating themselves as relational and collective are more concerned with the social consequences of health problems, such as being a burden to and unable to fulfil responsibilities towards loved ones (Uskul & Hynie, 2007). They are also more likely to report socially engaged emotions (emotions that motivate one to restore harmony in a relationship by compensating for harm done or repaying a debt, e.g. shame and embarrassment) about their illness rather than socially disengaged emotions (emotions that make salient one's inner attributes which are set in a social context, e.g. anger and frustration, see Kitayama *et al.*, 2006). Thus, one's sense of separation or connectedness with social others is associated with how illness consequences are represented and the emotional responses evoked by these consequences.

As seen in these examples, cross-cultural studies in illness representations point to clear differences in how beliefs about causes and consequences of different diseases are formed and responded to. Studies undertaken in the West show that causal beliefs are embedded in the physical and social world; in a collectivistic world, however, metaphysical beliefs and relationships with others are integral to an individual's worldview. In short, the health-care process is likely to be facilitated if attention is paid to patients' culturally shaped appraisals of their symptoms, the assumptions they make about the causes and how responses to medical advice are conditioned by the culturally shaped theories they use to understand their bodily responses. Understanding the illness theories used by patients offers the potential for improved communication, better treatment and enhanced adherence to medical advice.

Culture, health communication and persuasion

As summarised in the previous section, individualistic and collectivistic cultural perspectives provide a useful framework for understanding cultural representations of health and illness. Following from this, studies testing the effectiveness of health communications targeting an audience of diverse cultural backgrounds have begun to incorporate messages congruent with the audience's prevalent cultural frame. The underlying assumption is that if health communications match culturally salient characteristics, messages will feel more relevant and therefore will more likely influence judgement about appropriate behaviour. Indeed, research shows that messages are more persuasive when there is a match between the recipient's cognitive (e.g. Petty *et al.*, 2000; Williams-Piehotka *et al.*, 2005) or motivational (e.g. Cesario *et al.*, 2004; Mann *et al.*, 2004; Sherman *et al.*, 2006) characteristics and the content or framing of the message.

Research also suggests that matching health communications to motivational strategies adopted at varying levels by different cultural groups is a way to influence health behaviour change. Recent work by Uskul *et al.* (2009) on the use of dental floss tests the hypothesis that health messages will be more persuasive if they are congruent with the cultural patterns of promotion or prevention predominant in Western (individualistic) and Eastern (collectivistic) cultures. They draw on the literature suggesting that health messages congruent with a person's predominant motivational orientation are more effective than messages that are not (Mann *et al.*, 2004; Sherman *et al.*, 2006; Updegraff *et al.*, 2007). On the one hand, individuals who are predominantly approach-oriented (i.e. those who focus on the positive outcomes they hope to approach) report flossing more and are more generally persuaded in terms of attitudes and intentions when presented with a gain-framed health message about flossing (i.e. a message framed to convey the benefits of health-promoting behaviours). On the other hand, individuals who are predominantly avoidance-oriented (i.e. those who focus on the negative outcomes they hope to avoid) report flossing more and are more generally persuaded in terms of attitudes and intentions when presented with a loss-framed

health message about flossing (i.e. a message framed to convey the costs associated with failing to perform a health-promoting behaviour; see Sherman *et al.*, 2008, for a review).

Uskul and colleagues (2009) show that the individualistic white British participants are more persuaded (i.e. have more positive attitudes and stronger intentions to floss) when they receive the gain-framed message than when they receive the loss-framed message. By contrast, the collectivistic East Asian participants are more persuaded when they receive the loss-framed message than the gain-framed message. Furthermore, they demonstrate that cultural differences in the effectiveness of gain- and loss-framed messages in a dental health domain are mediated by a match between individuals' motivational orientation and the message frame. Thus, the interplay of individual difference factors (motivational orientation), sociocultural factors (cultural background) and situational factors (message frame) is likely to influence important factors related to health behaviour change, including attitudes towards and intentions to perform the health behaviour.

Studies that attempt to match message content to independent or interdependent aspects of the self of members of cultural groups yield somewhat inconsistent results. A study involving Mexican immigrant or African American participants (Murray-Johnson *et al.*, 2001) finds some effects when messages are matched to collectivism: Mexican immigrant participants and those who rate themselves as collectivistic find an AIDS message more frightening when it focuses on family-related consequences of AIDS. Some effects are found when messages are matched to individualism: African American participants and those who rate themselves as individualistic find the AIDS message more frightening when it focuses on self-related consequences of AIDS. Match results are found only for self-rated fear evoked by the message; no effects are observed for attitudes towards AIDS prevention or for intentions to prevent the risk of HIV infection. In other studies with African American participants, however, messages incorporating interdependent and not independent content are rated more favourably, thus showing the opposite effect to Murray-Johnson and colleagues' (2001) findings (e.g. Herek *et al.*, 1998; Kreuter *et al.*, 2004).

To address these inconsistencies, Uskul and Oyserman (in press) have employed a culturally informed social cognition framework (e.g. Oyserman & Lee, 2008; Oyserman & Sorensen, 2009) which suggests that what comes to mind at a given moment depends on the available situational cues and momentary cues can increase salience of cultural frames in information processing. They test the effectiveness of culturally matched health messages after making salient the dominant cultural frame using priming procedures. Specifically, they test the hypothesis that messages will be more persuasive when the message frame fits the dominant cultural frame. They find that matching health messages to salient cultural frames increases persuasiveness; further, culturally relevant messages are more persuasive if they come after being reminded of one's cultural frame. Individualist European Americans primed to focus on individualism are more persuaded by health messages associating health behaviour with negative physical consequences for the self, whereas collectivistic Asian Americans primed to focus on collectivism are more persuaded by health messages associating health behaviour with negative social consequences. Thus, message effectiveness can be increased by reminding potential listeners of their relevant cultural orientation. These findings also support the notion that the physical body and consequences for its well-being are perceived as part of the bounded self within an individualistic framework but that health appeals intending to improve health by focusing on the physical body are unlikely to be convincing when the self is socially embedded, as within a collectivistic framework.

Culture and coping

How people cope with health problems differs across cultural groups. Cultural differences, particularly in the use of social support have been shown in studies comparing individuals of Asian, European American and Asian American backgrounds (for a review, see Kim *et al.*, 2008). Studies using various methods and samples from different groups with Asian heritage (Chinese, Japanese, Korean and Vietnamese) have consistently found that Asians and Asian Americans seek less social support than European Americans (Kim *et al.*, 2006; Taylor *et al.*, 2004).

Studies conducted to examine the underlying reasons for cultural differences in social support seeking show that Asian Americans are more concerned that seeking support will cause them to lose face, to disrupt group harmony and to be criticised by others; these relationship concerns seem to discourage them from drawing social support from their social networks. Other potential factors such as the availability of unsolicited support and independence concerns are not related to their use of social support to cope (Kim *et al.*, 2006; Taylor *et al.*, 2004).

Given the positive effects of social support seeking on physical well-being in the form of reduced levels of depression or anxiety during stressful times (Fleming *et al.*, 1982), positive adjustment to a series of diseases such as diabetes and cancer (e.g. Holahan *et al.*, 1997; Stone *et al.*, 1999) and faster recovery speed from illness (e.g. House *et al.*, 1988), the finding that individuals of Asian origin tend to seek less social support than their European American counterparts may be worrying. Research, however, shows that while Asian groups tend to avoid explicit patterns of social support seeking, which involve the explicit disclosure and sharing of stressful events typically adopted by individuals in Western cultures, they benefit from implicit social support (the emotional comfort that one can attain from one's relationships without discussing problems caused by stressful events), without potential concerns about the relational implications.

This interaction between cultural group and social support has been shown in a number of studies, including one demonstrating the beneficial effects of culturally appropriate forms of social support and the harmful effects of culturally inappropriate forms of social support at the physiological level (Taylor *et al.*, 2007). An online diary study shows that European Americans report using explicit social support in coping with their daily stressors to a greater extent than do Koreans; Koreans report using implicit social support to a greater extent than do European Americans (Kim *et al.*, 2008). These findings point to the importance of exploring the meanings and associated benefits of social support in different cultural groups.

A recent set of studies underlines the need to test findings in Western groups against those in groups of other cultural backgrounds. Uchida *et al.* (2008) explored the relationship between emotional support

and well-being and physical health. In their initial study of college students, a positive effect of perceived emotional support on subjective well-being was found to be weak among European Americans; it disappeared when self-esteem is statistically controlled. In contrast, among Japanese and Filipinos perceived emotional support positively predicted subjective well-being, even after self-esteem is controlled. The authors replicated these findings in a second study with an adult sample using different well-being and physical health measures; in this study, perceived emotional support positively predicted well-being and health for Japanese adults, but such effects are virtually absent for American adults. As these studies show, culture moderates the impact of perceived emotional support on well-being and physical health.

Conclusion

Sociocultural environments play an important role in how health and illness are experienced. Psychological responses to physical experiences such as menopause or pain, understandings of causes and consequences of disease, effectiveness of health messages, use of social

support and its impact on physiological responses and many others, vary as a function of the characteristics of the sociocultural environments into which individuals are socialised. Evidence suggests that sociocultural factors can shape psychological constructs such as illness cognitions, attitudes and intentions – key constructs in such models of illness and health behaviour as the self-regulation model of illness cognition and behaviour (Leventhal *et al.*, 1984) and the theory of planned behaviour (Ajzen & Fishbein, 1980). To date, most health and illness models in psychology are designed and tested in a Western cultural context and are therefore likely to be biased. More research is certainly required as the incorporation of sociocultural factors into existing health models can contribute to a comprehensive understanding of the moderating factors that determine how illness cognitions are shaped or when behaviour is likely to change. It is time to collate the vast amount of knowledge accumulated in the hitherto disconnected subfields of cultural and health psychology and to explore the degree to which theories and models developed in the West can be used to understand health and illness-related psychological experiences elsewhere.

Discussion Points

- 1 What are some theoretical and practical implications of taking into account sociocultural factors in the study of health and illness?
- 2 The chapter introduces one theoretical framework commonly used to understand cultural differences and similarities in psychological phenomena. It also refers to other organising frameworks. Choose one of these alternative frameworks and discuss how it might be useful in making sense of cultural differences in the experience of pain.
- 3 Identify from the existing literature a health behaviour that has been reported to show variation across cultural groups. Discuss how this variation might be explained in reference to individualism–collectivism framework.
- 4 Discuss how a culturally informed social cognition framework can be applied in real-life settings in the domain of health communication.
- 5 Imagine you are a Western physician working in a Western country with many patients of East Asian background. What would be some of the issues that you would attend to in interacting with those patients?

Further Reading

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