



**THE UNIVERSITY OF QUEENSLAND**  
A U S T R A L I A

**Understanding Depression across Cultures:  
A Social Identity Perspective**

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## Abstract

There is now considerable evidence showing that culture shapes psychological processes, and this extends to depression and psychopathology more generally. In particular, an understanding of the processes and mechanisms through which culture influences depression is important not only to clinical practice, but also in the designing of interventions to promote resilience to depression. For example, such cultural understanding helps therapists to determine whether and when clients will be influenced by culture and its norms, and accordingly, the impact on their expression, assessment, diagnosis, and treatment of depression. The present thesis adopts a social identity perspective to advance research on the cultural underpinnings of depression in three research streams that investigate (a) the symptomatic presentation of depression, (b) cultural factors associated with vulnerability, and (c) resilience, to depression.

Much of the work on the relationship between culture and the expression of depression has centered on Asians' tendency to emphasize somatic symptoms of the condition over psychological symptoms. However, despite extensive investigation of Asian somatization, there has been little progress in explaining *how* and *when* culture affects depression expression. To address this gap, the studies in Chapter 2 drew on social identity principles and processes to explain when culture and its norms would affect somatization. Three studies were conducted to investigate the role of cultural identity on somatization; predicting that norm endorsement would occur only when individuals identified with their culture. The key finding was that among Asians, normative expectations of collectivism predicted somatization, but only when participants strongly identified with Asian culture. These findings highlight the centrality of identification processes to cultural influence on depression.

Investigations of culture and depression expression tend to conceptualize the Western perspective as the frame of reference or norm. That is, Asian somatization is commonly viewed as dysfunctional in Western contexts, whereby Asians and their emphasis on somaticizing depression is often portrayed as “that which needs to be explained”. In Chapters 3 and 4, we shifted focus to studying the effect of Western culture on depression, an arguably neglected area of research. More importantly still, the socially potent nature of cultural norms in exerting influence tends to be overlooked in the literature of this field. Hence, the studies in these chapters drew on a norm-based approach to characterize cultural influence, and investigated the effects of specific collective-level cultural factors (i.e., social norms) associated with vulnerability to depression among Westerners.

Along these lines, the study reported in Chapter 3 examined whether and why social norms communicating the value of happiness (that happiness is desirable) could potentially make individuals feel worse (i.e., more depressed). We also investigated differences in these effects across cultures (Asian, Western). In this study, happiness norms were found to be associated with higher levels of depression symptoms among Westerners, but lower levels of symptoms in Asians. Additionally, we found that negative self-reflections in response to unhappiness mediated this relationship for Westerners only. This suggests that the influence of happiness norms differ across cultures. In Chapter 4, this reasoning was extended and used to examine social norms for unhappiness (that unhappiness is undesirable) as a potential explanatory mechanism underlying the commonly demonstrated cultural differences in the negative emotion-wellbeing link. Here, the research focused on determining whether such norms could help explain why negative emotions have fewer adverse effects on the wellbeing of Asians than they have for Westerners' wellbeing. This study showed that unhappiness norms could help to account for the finding that negative emotions only have a limited impact on the wellbeing of Asians; underscoring the socially potent nature of cultural norms.

In the final empirical chapter, the research focused on studying the cultural factors associated with resilience to depression. In four studies, we examined whether belonging to multiple groups protected against developing depression for Asians to the same extent as Westerners. Results showed that multiple group memberships conferred fewer wellbeing benefits for Asians, relative to Westerners. Moreover, the findings suggested that this was a reflection of Asian norms about relationships and support seeking, making Asians more reluctant to utilize their group memberships for support resources due to concerns about burdening others. The evidence highlights that culture and its norms can influence the extent to which individuals draw on support resources from group memberships, which in turn, affects their wellbeing and depression.

In sum, the present thesis demonstrates the utility of social identity processes and mechanisms (i.e., cultural identification, cultural norms, multiple group memberships) to explain how, when, and why culture shapes depression expression. This research has important practical implications. In clinical practice, such cultural understanding can help therapists become more aware of cultural variability, and how (and the degree to which) clients will be influenced by culture and its norms. Additionally, in designing interventions to promote resilience to depression, the findings support the targeting of social variables that are associated with depression.

### **Declaration by author**

This thesis is composed of my original work, and contains no material previously published or written by another person except where due reference has been made in the text. I have clearly stated the contribution by others to jointly-authored works that I have included in my thesis.

I have clearly stated the contribution of others to my thesis as a whole, including statistical assistance, survey design, data analysis, significant technical procedures, professional editorial advice, and any other original research work used or reported in my thesis. The content of my thesis is the result of work I have carried out since the commencement of my research higher degree candidature and does not include a substantial part of work that has been submitted to qualify for the award of any other degree or diploma in any university or other tertiary institution. I have clearly stated which parts of my thesis, if any, have been submitted to qualify for another award.

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**Publications during candidature**

- Chang, M. X. L., & Jetten, J.** (2015). Understanding cultural identification: Integrating the intersubjective approach with social identity theorizing. *Journal of Cross-Cultural Psychology, 46*(10), 1291-1295. doi:10.1177/0022022115604394
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<b>Contributor</b>	<b>Statement of contribution</b>
Xue-Ling Melissa Chang (Candidate)	Wrote manuscript (100%)
Jolanda Jetten	Edited manuscript and provided critical feedback (100%)

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**Statement of parts of the thesis submitted to qualify for the award of another degree**

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**List of abbreviations used in the thesis**

CIMH = Cultural Influences on Mental Health Model

CIRSRM = Culturally Informed Illness Representation Self-Regulation Model

SIA = Social Identity Approach

MGM = Multiple Group Memberships

## Chapter 1: Introduction<sup>1</sup>

Culture shapes human behavior and experience in ways that are subtle, but powerful. The central role of culture permeating various psychological processes is evident from research over the last two decades establishing substantial cultural variation in cognitive, emotional, and motivational processes (see Heine, 2012; Heine & Ruby, 2010, for reviews). In fact, cultural factors have also been found to be important in influencing the etiology, expression, assessment, diagnosis, and treatment of psychopathology (Marsella & Yamada, 2010). Notably, this is reflected in the inclusion of a new clinical tool in the DSM-5, the *Cultural Formulation Interview*, which aims to help clinicians assess cultural factors influencing clients' perspectives of their symptoms and treatment options (American Psychiatric Association, 2013). Despite the increased recognition that 'culture' matters in psychopathology (e.g., classification of cultural group differences in symptom presentation, assessment, and treatment outcomes), *how*, *when*, and *why* it shapes psychopathology has been much less explored (see Ryder, Ban, & Chentsova-Dutton, 2011; Ryder & Chentsova-Dutton, 2015, for similar arguments). Yet, examining these processes is critical because a psychology of culture and psychopathology is at best incomplete if it does not also shed light on these questions.

### Defining Culture

Culture is an elusive concept and it has been defined in a myriad of ways (Kroeber & Kluckhohn, 1952). Despite this, there is general agreement that culture consists of shared elements (e.g., ideas, values, and practices; Chiu, Gelfand, Yamagishi, Shteynberg, & Wan, 2010; Shweder & LeVine, 1984) that provide the standards for perceiving, believing, evaluating, communicating, and acting among a collection of interdependent individuals, and is transmitted from generation to generation with modifications (Leung, Chiu, & Hong, 2010; Triandis, 1996). This definition is therefore adopted as the working definition of culture in the thesis. In the next section, we will begin by outlining the way that culture influences depression.

### Culture and Depression

Over the last two decades, a body of research has demonstrated substantial cultural variation in the modes of expression, explanation, and personal and social response to psychological distress and dysfunction. In combination, this work provides compelling

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<sup>1</sup> Portions of this chapter are from a manuscript that has been published in *Journal of Cross-Cultural Psychology*: Chang, M. X. L., & Jetten, J. (2015). Understanding cultural identification: Integrating the intersubjective approach with social identity theorizing. *Journal of Cross-Cultural Psychology*, 46(10), 1291-1295.

evidence of the importance of cultural influence in the etiology, expression, assessment, diagnosis, and treatment of psychopathology (see Hwang, Myers, Abe-Kim, & Ting, 2008; Kirmayer & Ryder, 2016; Marsella & Yamada, 2010; Tanaka-Matsumi & Draguns, 1997, for reviews). One of the first systematically reported cross-cultural differences in the study of culture and psychopathology was the apparent rarity of depression in Chinese cultures (Kleinman, 1982). This has since been substantiated by research showing that the prevalence rates of depression tend to be lower in Asian compared to Western cultures; painting Asian societies to be relatively free of depression. For example, in a 10-nation epidemiological survey, it was found that, while the lifetime prevalence rates of Major Depression were found to be 1.5% and 2.9% in Taiwan and Korea respectively, the rates were dramatically higher in North America (United States 5.2%, Canada 9.6%; Weissman et al., 1996, see Table 1). Along these lines, a group of studies conducted by the International Consortium in Psychiatry Epidemiology found that Japan reported the lowest prevalence rate of depression (3.0%) while the United States reported the highest (16.9%; Andrade et al., 2003). Similarly, more recent epidemiological surveys found lifetime prevalence rates of Major Depression to be lower in China (3.6%; Lee et al., 2009) and Singapore (5.8%; Chong et al., 2012) compared to the United States (16.6%; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012).

Table 1  
*Lifetime Rates for Major Depression in 10 Nations as Reported in Weissman et al. (1996).*

<b>Nations</b>	<b>Lifetime Rates</b>
Taiwan	1.5%
Korea	2.9%
Puerto Rico	4.3%
United States	5.2%
West Germany	9.2%
Edmonton, Alberta	9.6%
Christchurch, New Zealand	11.6%
Florence, Italy	12.4%
Paris, France	16.4%
Beirut, Lebanon	19.0%

The disparities in the prevalence of depression have led some researchers to question whether these reflect truly differences in depression prevalence, or whether they are the result of cultural differences in the symptomatic and clinical presentation of depression (Parker, Cheah, & Roy, 2001a; Parker, Gladstone, & Tsee, 2001b; Ryder & Chentsova-Dutton, 2012; Ryder, Yang, & Heine, 2002). To account for this, Asian somatization has been proposed as a possible explanation for the low rates of depression found in Asian cultures. This research centers on the so-called bias among Asians to emphasize somatic symptoms of depression (i.e., lack of sleep, poor appetite, body aches, headaches) over psychological symptoms (i.e., feeling sad, worthlessness; Kleinman, 1982; Lu, Bond, Friedman, & Chan, 2010; Marsella, 1980; Parker et al., 2001a; Ryder, et al., 2008).

Other researchers have contested this reasoning, arguing that conceptual and methodological problems cannot fully explain away the cross-cultural differences in prevalence and these disparities may be in part of real differences in depression prevalence (Kessler et al., 2008; Kessler & Bromet, 2013). For example, it has been suggested that Asian sociocultural factors (e.g., traditional cultural concepts with elements of “fatalism”) may provide some protection against depression (Parker et al., 2001b). This reasoning is consistent with the growing evidence showing that compared to Westerners, Asians are more likely to accept negative emotions as inevitable and as a part of reality (e.g., viewing emotional illness as part of ‘life’; Peng & Nisbett, 1999). Asians may even view some degree of unhappiness as desirable (e.g., as a source of motivation to improve the self; Miyamoto, Ma, & Petermann, 2014; Uchida & Kitayama, 2009). Extending on these ideas, research has increasingly shown negative emotions to adversely influence the wellbeing of Asians to a lesser degree than Westerners (Curhan et al., 2014; Kitayama et al., 2015; Kuppens, Realo, & Diener, 2008; Miyamoto et al., 2013).

Taken together, this suggests that relative to Asians, Westerners may be less accepting of negative emotions, and less able to cope with their negative emotions. This may result in lower rates of depression among the former than the latter. In fact, along these lines, a growing body of work shows that Western sociocultural factors (i.e., Western emphasis on the pursuit of happiness and a relative devaluation of unhappiness) may rather ironically contribute towards vulnerability to depression (Bastian et al., 2012; Ford, Shallcross, Mauss, Floerke, & Gruber, 2014). This work has found the individual pursuit of happiness (i.e., wanting and valuing happiness at a personal level) to be paradoxically associated with reduced wellbeing, higher depressive symptoms, and compromised social outcomes (Ford et al., 2014; Mauss et al., 2012; Mauss, Tamir, Anderson, & Savino, 2011). Perhaps most

pertinent to the study of cross-cultural differences associated with depression, though, are findings from the only cross-cultural study available in this field. In this study, Ford et al. (2015) found that individual-level motivations to pursue happiness predicted lower wellbeing in Americans, but higher wellbeing in Asians; suggesting a culturally specific effect. Despite this increasing interest, much of the work on the study of cross-cultural difference in depression has focused on, and continues to examine, the tendency for Asians to emphasize somatic symptoms of depression. So, what is our current theoretical understanding of the relationship between culture and depression expression?<sup>2</sup>

### **Theoretical Understandings of Cultural Variation in Depression Expression: Prevailing Cultural Conceptual Frameworks**

In recent years, two conceptual frameworks proposed to understand the influence of culture on psychopathology have emerged — the Cultural Influences on Mental Health Model (CIMH; Hwang et al., 2008) and the Culturally Informed Illness Representation Self-Regulation Model (CIRSRM; Wong, Tran, Kim, Van Horn Kerne, & Calfa, 2010). According to the CIMH, culture contributes to differences in the (a) prevalence of mental illness, (b) etiology of disease, (c) expression of distress, (d) diagnostic issues, (e) help seeking pathways, and (f) treatment issues. This highlights the many domains of psychopathology that culture may influence. Specifically, the model states that cultural norms and beliefs shape the manner in which distress is expressed. That is, the sociocultural environment that one is in (i.e., one's cultural background) acts as a contextual backdrop, influencing cultural conceptions of illness (e.g., what an illness is), symptom recognition and tolerance, the mode in which it is expressed and communicated, and the social meanings associated with this expression and communication (Hwang et al., 2008; Marsella, 1980). The CIRSRM, on the other hand, argues that Asian cultural worldviews (i.e., mind-body holism, collectivism, and dialecticism) influence mental illness lay beliefs, which in turn, influence Asian Americans' professional help seeking behaviors (Wong et al., 2010). Importantly, this model acknowledges that Asian Americans vary in the extent to which they embrace these worldviews (albeit not explaining in detail why this might be). This framework, however, has only focused on the influence of culture on help seeking behaviors (i.e., likelihood of help seeking), and not the expression of depression.

What is similar in both frameworks is that they recognize the importance of cultural norms and beliefs in shaping psychopathology. Specifically, in understanding Asian

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<sup>2</sup> In this thesis, Asian largely refers to Chinese, but also includes groups from both East-Asia (e.g., Hong Kong, Taiwan, Singapore) and Southeast-Asia (e.g., Malaysia, Indonesia).

somatization, both models implicitly posit that Asian normative expectations might explain higher somatization among Asians. This focus on normative expectations is consistent with the increased interest among cultural researchers in understanding the role that social norms (or collective-level representations) play in a range of psychological processes (Chiu et al., 2010; Morris, Hong, Chiu, & Liu, 2015). Norms have been found to provide insight into cultural differences above and beyond personal values and beliefs (Fischer et al., 2009; Shteynberg, Gelfand, & Kim, 2009; Zou et al., 2010). However, both frameworks are limited in several ways. Neither model specifically theorizes the circumstances in which Asian normative expectations might explain higher somatization among Asians. For example, the models do not help us understand *how* and *why* culture, with its normative expectations, has the power to influence depression expression (e.g., the social influence process, the socially potent nature of norms). Furthermore, these frameworks do not specify *when* culture influences depression expression (e.g., when culture will lead to somatization), or *how* and *why* normative expectations of depression expression are communicated among individuals. Answering these questions is important because it would allow us to identify the psychological processes responsible for observed cultural differences.

In particular, despite the fact that cultural psychologists have emphasized the dynamic nature of cultural influence in recent years (Hong, Morris, Chiu, & Benet-Martinez, 2000; Ng, Han, Mao, & Lai, 2010; Oyserman & Lee, 2008), both frameworks (CIMH, CIRSRM) predict that cultural knowledge is chronically salient and has a constant influence on one's beliefs and behaviors. Yet, it has been argued in dynamic approaches to culture that whether cultural knowledge comes to the fore in an individual's mind depends on the extent to which it is accessible in a specific situation (Hong et al., 2000; Oyserman & Lee, 2008). As situations differ in the degree to which cultural knowledge is accessible, simply belonging to a culture will therefore not be sufficient for culture and its normative expectations to have influence. This suggests that the influence of culture on how one thinks, feels, and acts is context-dependent, and accordingly, quite malleable. However, because both CIMH and CIRSRM treat culture as a somewhat stable "in-the-head" trait rather than a dynamic state that can vary, neither model predicts when culture will lead to somatization.

As the above highlights, the prevailing literature on cultural conceptual frameworks fails to comprehensively explain the processes and mechanisms through which culture shapes depression expression. The lack of relevant theory to understand these processes is particularly problematic in a diagnostic context — failure to correctly detect and diagnose depression (and psychopathology more generally) increases the risk of inadequate or

inappropriate treatment (Comino, Silove, Manicavasagar, Harris, & Harris, 2001; Hwang et al., 2008). Furthermore, this cultural understanding is necessary when targeting intervention. For instance, research has found that the use of metaphors that match with a client's cultural worldviews (Smith, Rodriguez, & Bernal, 2011) and incorporation of cultural beliefs about symptoms, etiology, consequences, and appropriate treatment (Benish, Quintana, & Wampold, 2011) increases the effectiveness of psychotherapy. This demonstrates the importance of determining whether (and the degree to which) culture and its norms influence individuals and their depression expression in clinical practice. This is essential because it is through understanding these processes that we can establish for whom (and when) psychotherapies need to be culturally adapted.

In an attempt to fill this gap, this thesis draws on one particular theoretical framework — the social identity approach (SIA). This approach acknowledges the importance of normative expectations and identity processes in understanding cultural influences on psychopathology through its capacity to explain the context-dependent nature of cultural influence. The value of this analysis is that it has the potential to provide the necessary theorizing (i.e., principles and mechanisms; Tajfel & Turner, 1979; Turner, 1991; Turner, Oakes, Haslam, & McGarty, 1994) needed to comprehensively explain cultural influence (i.e., collective-level factors) on individual's depression expression. In this way, the SIA provides an analytical framework that helps us move beyond simply seeing a relationship between culture and depression expression to a position where this relationship and various influences can be better understood.

### **The Social Identity Approach**

The social identity approach (comprised of social identity theory; Tajfel & Turner, 1979, and self-categorization theory; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987; Turner et al., 1994) provides a framework to understand the interdependencies between personal self-systems and social-systems. It takes as a starting point the idea that collective phenomena cannot be adequately explained in terms of isolated individual processes or interpersonal interaction alone. One of the core insights of the SIA is that collectives shape individual psychology (e.g., perceptions, beliefs, and behaviors) when the collective is internalized into a person's *sense of self*. Specifically, it proposes that social group membership (e.g., culture, gender) informs our self-understanding, and along with that membership comes knowledge of the characteristics that define the group and appropriate normative behavior to think, feel, and act (e.g., content of identity; Hogg, 2003; Turner et al., 1994). More importantly still, it recognizes that objective membership of a shared category

(i.e., groups an individual is a member of in an absolute sense) is less important than their sense of belonging to the group (Turner et al., 1987). That is, it is only when individuals have psychologically internalized the group as an important part of the self, thereby *seeing themselves* as members of the group, that the group and its norms exert a profound influence on the attitudes and behaviors of the individual. The principles and values that come to define us as individuals are thus the ones that we derive from the social groups to which we belong and with whom we identify (i.e., social identification), forming a socially constructed sense of who “we” are and what “we” do; but also who “we” are not and what “we” do not do (Oyserman & Destin, 2010; Oyserman & Markus, 1998).

Self-categorization theory (Turner et al., 1987; Turner et al., 1994) takes this further to explain the processes through which one shifts from defining oneself in terms of personal identities to shared social identities (i.e., when particular social identities become salient, meaningful, and self-defining; whereby the group becomes “self”). Specifically, it argues that whether, and which, social identities become salient is *interactively determined by fit* (i.e., comparative and normative fit; Oakes, 1987; after Bruner, 1957) and *accessibility* (the readiness of perceivers to use them; Oakes, Haslam, & Turner, 1994). This means that individuals will be inclined to define and understand themselves in terms of identities that allow them to make sense of their current circumstances (fit) and social identities that have proved to be useful or meaningful in the past (accessibility; see Haslam, 2004, for review). As an example to illustrate the fit hypothesis, an Asian female is more likely to define herself as Asian (having shared identity with other Asians) when in a comparative context that includes both Asians and Westerners, rather than just Asians. This is because here the differences between herself and other Asians will be perceived to be smaller than the differences between herself and Westerners (i.e., comparative fit defined by meta-contrast principle). Alternatively, when in a context that includes Asian females and males, an Asian female may be more likely to define herself as female because this will be more fitting (i.e., differences between females and males may appear to be larger than the differences within females). In addition, an Asian female will tend to define herself as Asian to the extent that this way of categorizing herself is consistent with her normative understanding (in terms of identity content) of the similarities and differences between Asians and Westerners (normative fit), and the identity is meaningful to her (accessible). This explains why identification (and having prior involvement in the group) is one particularly important factor in increasing the likelihood of the social identity becoming salient when contextual factors make it fitting. What this suggests is that more valued and meaningful social identities have a



greater likelihood of being invoked to make sense of the world. Importantly too, self-categorization theory argues that when a person self-categorizes in terms of a particular group membership, the individual internalizes the group's defining values and characteristics (or group norms), with them becoming self-relevant to understanding the self and one's place in the world. This suggests that acting in accordance with the content of identity (or norm adherence) reflects the fact that the individual has taken on the group identity as an important part of self (Turner & Oakes, 1989).

Although the social identity approach was originally developed to explain intergroup phenomena (e.g., particularly discrimination and prejudice; Tajfel, 1970), it has become a dominant social-psychological model of group processes that has been influential in topics as diverse as leadership, communication, motivation, and collective action (see Haslam, Ellemers, Reicher, Reynolds, & Schmitt, 2010). Increasingly, researchers have also begun to use it as a framework for understanding health and wellbeing, including depression (Cruwys, Haslam, Dingle, Haslam, & Jetten, 2014; Haslam, Jetten, Postmes, & Haslam, 2009; Jetten, Haslam, & Haslam, 2012). The focus on analysis of group processes and the collective self in understanding collective phenomena, and its recent application in the health domain, makes this approach particularly useful to enhance our understanding of the influence of culture (which is best conceptualized as a collective-level phenomenon; Kitayama & Uskul, 2011) on depression. In this regard, we have at our disposal a rich set of principles and mechanisms supported by empirical research that can help us to understand how, when, and why culture influences depression expression. Specifically, we can draw on the social identity approach to explain (a) how individuals' behavior is shaped by collective-level representations (e.g., social identity-contingent normative phenomena; Turner, 1991), (b) how collective-level representations and groups are also reciprocally shaped by individuals (see Postmes, Haslam, & Swaab, 2005a), (c) when individuals define themselves as group members (analysis of social identity salience; Oakes, 1987; Oakes, Turner, & Haslam, 1991), (d) social identity motivations (Haslam, 2004; Hogg, 2006; Oyserman & Destin, 2010), and (e) how shared identity shapes communication (see Haslam, 2004). These are detailed in the next section.

### **Understanding Cultural Variation in Depression Expression:**

#### **Rediscovering the Social Identity Perspective**

This section aims to clarify the relevance of some key social identity principles and processes to understanding the relationship between culture and depression expression. Through this analysis, we are able to specify more clearly the psychological processes underlying the influence of culture and its normative expectations on depression expression.

Specifically, this analysis enables us to understand not only whether there are cultural differences in depression expression, but also, how, when, and why these differences would emerge.

### **Shared Identities as a Basis for Social Influence and Self-Definition**

Two key ideas from the SIA are central to our understanding of the relationship between culture and depression expression. First, social identities offer the scope to define the content of who we are (i.e., to describe ourselves, and to inform our own beliefs and behaviors). Because social identities have the power to structure our self-concepts (and the associated norms and values), they fundamentally affect the way we think, feel, and act. Second, the strength of social identification determines the degree to which we define ourselves as members of a particular group. In turn, this shapes the extent to which our beliefs and behaviors are guided by the content of this identity, and with group norms and values.

Significantly, these features highlight the importance of *shared identity* as an underlying psychological process. It suggests that normative behavior (or norm adherence) is a product of social identification — an indication that the individual has taken on the identity as an important part of self (Turner & Oakes, 1989). More importantly still, it posits that shared identity is what makes social influence possible (Turner, 1991). This means that when individuals perceive themselves to share identity with other members of a given group, there is a greater likelihood that they will turn to the group norms as a guide for behavior. Social influence is thus only possible when we perceive ourselves as sharing social identity (“us”), listening to and be influenced by those with whom we share identity (Cruwys et al., 2012; Terry, Hogg, & White, 1999; Turner, 1991). This is because other ingroup members are the ones whom we trust and respect most (e.g., Haslam, 2004; Tanis & Postmes, 2005), and see as a valid point of reference against which to judge what is appropriate or correct. Validation from others with whom we share identity also increases our confidence in the accuracy of the group consensual representations (i.e., group norms; Baron et al., 1996; Smith & Postmes, 2011), allowing these norms and other group members to have the power to influence us. Support for this social identity model of social influence has been found for a range of health behaviors, including exercise (Terry & Hogg, 1996) and eating (Louis, Davies, Smith, & Terry, 2007; Smith et al., 2008). These studies demonstrate that the effects of perceived group norms are more pronounced for individuals who identify strongly with the reference group.

Overall then, the SIA principles outlined suggest that known and consensually shared properties of the group (i.e., group norms or group consensual representations) can influence individual behavior once a person subjectively defines themselves as a member of the group and internalizes group norms and behaviors. It has been posited that culture can be conceptualized as a specific social identity with collectively shared notions of normative group behaviors (i.e., cultural normative expectations; Wan, Dach-Gruschow, No, & Hong, 2010). The SIA predicts that to answer how, when, and why culture influences depression expression (i.e., the mechanisms), we need to focus on cultural identification — the degree to which one identifies with the culture or perceives themselves as sharing identity with other members of a cultural group, and in turn, internalizes and endorses the content of this identity. It is assumed then that collective cultural representations are meaning systems that exist in the collective mind, influencing and affecting individuals' knowledge to construct their cultural selves.

This theorizing can help explain the likelihood that individuals will accept and reproduce these cultural representations. That is, culture influences one's belief and behavior to the extent that the individual *identifies* with the culture, explaining how and why culture in the form of cultural representations become part of individuals' cultural selves. Individuals will therefore only participate actively in the reproduction of the cultural representations to the extent that they identify with the culture. After all, "others" can only affect our behaviors to the extent that they are perceived as sharing identity. For example, an Asian female who defines herself as an Asian is more likely to be influenced by her Asian friends when deciding what is the right and proper thing to do in disagreements (e.g., whether it is a good idea to suppress emotions, which is a culturally typical pattern of Asians, or express emotions, which is more culturally typical of Westerners; Markus & Kitayama, 1991).

Supporting this argument, a body of research shows that individuals who identify strongly with their culture are motivated to act in accordance with the expected normative characteristics of the group (e.g., Chao, Zhang, & Chiu, 2010; Gouveia, de Albuquerque, Clemente, & Espinosa, 2002; Heaven, 1999; Jetten, Postmes, & McAuliffe, 2002; Zou, Morris, & Benet-Martinez, 2008). For illustration, Jetten et al. (2002) found that in an individualistic culture (i.e., North America), individuals who identified highly with their national identity were more individualistic than were low identifiers, whereas in a collectivistic culture (i.e., Indonesia), higher identification as Indonesians was associated with greater endorsement of collectivism.

This process is also evident in research examining the influence of cultural identity on health behaviors (see Unger, 2011, for review). Research has suggested that women's cultural identities can influence their decisions about smoking, such that among Asian American women, an Asian cultural identity may be protective against smoking whereas a Westernized (or American) cultural identity may be a risk factor for smoking. This is because smoking is considered to be more undesirable, and hence less normative, among women in Asian, relative to Western, cultures (An, Cochran, Mays, & McCarthy, 2008; Hsia & Spruijt-Metz, 2008; Weiss & Garbanati, 2006). Specifically, this line of work has found that among Asian American women, endorsement of American cultural identity (consisting of norms prescribing smoking as less undesirable) was associated with stronger social norms about the acceptability of smoking and a higher prevalence of smoking (Weiss & Garbanati, 2006). The importance of cultural identity is further supported in a study conducted by Rao et al. (2007) among South Indian psychiatric patients. This study showed that more Westernized participants (assessed with an acculturation measure) were more likely to report their psychological symptoms when expressing distress — a presentation more consistent with Western (rather than Asian) mode of depression expression. Critically, the evidence taken together suggests that cultural identification may be a critical factor in the expression of depression. This means that it is only when cultural identity is central to our sense of self, that we are most likely to be influenced by culture and its normative expectations — even to the extent of influencing our interpretation and response to keys aspects of health and wellbeing (e.g., decisions about performing behaviors related to health). This reasoning can be extended to understanding Asian somatization. Among Asians, increased somatic symptom expression should occur to the extent that one identifies with Asian culture and in turn, is more sensitive to, and willing to endorse, Asian cultural norms and scripts.

Following up on these ideas, the SIA theorizing also helps to explain why there is variation in the extent to which members of a cultural group identify with and thus endorse the group's norms (Tajfel & Turner, 1979). The SIA makes it clear that not all social group memberships (e.g., culture, gender) are incorporated into a person's subjective sense of self. Rather, what matters most is the way that individual's relationship with others is defined (i.e., whether there is a sense of shared identity between the self and others). Therefore, mere belonging to a culture (i.e., a demarcated population as defined with respects to certain geographic or ethnic characteristics) and even knowledge of a culture does not mean that one will automatically endorse and act in accordance with the normative expectations of that culture (Hong, Wan, No, & Chiu, 2007; Oyserman, Kemmelmeier, Fryberg, Brosh & Hart-

Johnson, 2003; Spiro, 1992). Indeed, individuals are not passive recipients of cultural representations. Instead, they are active agents in how they live out their culture (Herman, 2001). They may either reject normative characteristics of the culture or selectively identify with that part of the culture that suits them (Chiu & Chen, 2004; Wan et al., 2010).

In understanding Asian somatization, identification processes help to explain why not all Asians somaticize: not all Asians will see Asian culture and its norms as self-relevant, thereby varying in the degree to which they endorse Asian norms and this affects the degree of somatization. This reasoning is consistent with the literature differentiating cultural knowledge from the cultural self, where it is argued that acquisition of culturally-relevant knowledge does not necessarily entail identification with the culture and endorsement of its norms (Wan et al., 2007; Wan et al., 2010). What is more, there is evidence that identification is essential in the rejection of group norms and behaviors. At times, it is precisely because individuals care for the group that they decide to challenge group norms and practices in an attempt to instigate positive change (Jetten & Hornsey, 2014). Together, the evidence highlights that the SIA helps understand whether (and why) individuals are influenced by culture or not, and also, whether (and why) they want to live up to normative expectations or not (and express depression in a manner that is consistent with cultural norms).

### **Culture is Dynamic: Identity Salience Helps Understand When and Which Identity Matters**

A sense of shared social identity can be seen to provide the psychological foundation for meaningful forms of social behavior (Turner, 1982). Key here is also the idea that for a social identity to affect beliefs and behaviors, it must be *psychologically salient* as the basis for perception and self-conception. We all, however, belong to many groups and therefore can perceive ourselves in many different ways (e.g., culture, gender). What is more, with increasing globalization, more and more people are becoming bicultural or even multicultural, and therefore have various cultural identities. Significantly then, when are these social identities a salient part of self-concept and when are they not, and which of these different social identities will be salient in any given context? Understanding this is critical because which identity one draws on to define themselves in a particular context has distinct implications for their beliefs and behaviors.

Accordingly, the SIA proposes that social identity salience is another way in which to answer the “when” question (Oakes, 1987; Oakes et al., 1991). The focus here is on *contextual* factors making particular social identities and their norms salient, thereby influencing one’s beliefs and behaviors. As outlined, fit (comparative and normative fit) and

accessibility (in particular identification) have been identified as important factors in increasing the likelihood of a particular social identity becoming salient. In other words, identification (which plays a role in affecting accessibility) interacts with principles of fit to determine identity salience (see Haslam, 2004, for review). Using this theoretical framework then, we are in a position to explain more precisely when (or under what conditions) one will be influenced by culture and its norms. The SIA suggests that one will define and understand themselves as Asian and live up to Asian normative expectations to the extent that Asian cultural identity and its norms are salient (as influenced by the factors of fit and accessibility). Asian identity (and its content) is more likely to influence an individual's depression expression if this way of categorizing themselves helps them to make sense of their current circumstances, and the identity is meaningful to them. Importantly, this means that as the circumstances (i.e., comparative contexts) change, so too will the identity one draws on to define themselves (because it may not be as fitting in the current context; see meta-contrast principle described earlier). As an illustration, an Asian psychologist defining oneself as Asian will be fitting at a football match between Asian and Western countries (such as during FIFA World Cup), but less so in a work context where one is surrounded by Asian economists.

Substantiating the use of the SIA as a theoretical framework to understand the influence of culture in depression expression is a large body of research demonstrating the dynamic nature of culture and cultural identity (e.g., Hong, Ip, Chiu, Morris, & Menon, 2001; Hong et al., 2000; Oyserman & Lee, 2008; Shelton & Sellers, 2000; Tsai, Chentsova-Dutton, & Wong, 2002). This is reflected in two prominent cultural theoretical approaches, the dynamic constructivist approach (Hong et al., 2000) and the situated cognition approach (Oyserman & Lee, 2008). This line of work has found that priming bicultural individuals (i.e., Westernized Hong Kong Chinese) with either American or Chinese cultural icons led to responses that were typical of the primed culture (Hong et al., 2000). For example, in studies using attribution tasks, Westernized Hong Kong Chinese would make more situational attributions and fewer individual attributions when primed with Chinese than American cultural icons (leading to Chinese cultural frames to become salient; Hong et al., 2000). This is in line with findings from studies on cultural differences in causal attributions showing that when explaining events, Asians preferred contextual explanations whereas American participants preferred dispositional ones (Choi, Nisbett, & Norenzayan, 1999). The research therefore highlights that individuals can switch cultural frame in response to contextual cues. This suggests that the influence of culture is not constant and rigid, but dynamic.

Providing further support for the use of social identity theorizing to understand culture and depression expression, empirical research has substantiated the premise that fit, accessibility, and identification are important determinants of social identity salience (Sussman, 2000; Turner et al., 1994; Yip, 2005). For example, in line with the *fit* or meta-contrast principle, it has been argued that heritage cultural identity is often not salient while one resides in their home culture, but is heightened once in a foreign cultural environment (e.g., an expatriate in a new country; Sussman, 2000). More specifically, cultural identity may become salient when the new comparative context is extended to include different others (leading to an intergroup context), whereby there is a salient meta-contrast between culture categories. It should be noted, however, that even without identity salience, in both contexts, cultural norms provide a behavioral repertoire of what people perceive to be acceptable and normal.

More pertinent still, there is evidence showing the significant role that *salient* identities play in determining symptom appraisal and responses, as well as health-related norms and behavior (see Haslam et al., 2009, for review). St. Claire et al. (2008) found that individuals reported more intense cold symptoms when they were primed to think of themselves as a member of a group of people with colds. Along these lines but focusing on cultural identity, research has demonstrated that simply making salient a particular social identity that people hold (i.e., ethnic identity, national identity) is enough for them to endorse healthy (or less healthy) behaviors that are in line with that group's norms (e.g., high salt intake; Oyserman, Fryberg, & Yoder, 2007; Tarrant, Hagger, & Farrow, 2011). Perhaps the most compelling source of evidence supporting this framework in a cultural context, albeit not directly pertaining to depression expression, comes from Tam et al. (2012). In this study, it was found that when Chinese (as compared to American) cultural ideas were activated (i.e., made salient) among Hong Kong Chinese students, wellbeing was more contingent on satisfaction with relationship-related domains and less on satisfaction with self-related domains. This finding is consistent with the greater emphasis placed on maintaining harmony in relationships in Chinese collectivistic cultures. The finding highlights that the perception of wellbeing can be dynamically constructed, and that it varies according to salience of cultural ideas.

Overall, considering when and whether cultural identity is *salient* in the here-and-now (out of the many social or even cultural identities that one has) is key to understanding the influence of culture on depression expression. Here, it should be noted that the SIA also recognizes that there are stable elements that determine the influence of culture. For example,

one's *prior* experience and involvement in the group (e.g., social identification) plays a role in increasing the likelihood of the social identity becoming salient (i.e., chronically accessible; Hogg & Reid, 2006). Accordingly, this contributes to patterns of accessibility that give culture an enduring and stable quality, and it increases the likelihood that one will experience the influence of identity and its content as more stable. Furthermore, social identity researchers have acknowledged and recognized the important role of history in shaping collective identity (David & Bar-Tal, 2009; Jetten & Wohl, 2012). Additionally, in the SIA, group consensual representations (i.e., group norms) are conceptualized as enduring to the extent that group goals and relations are too (which they often are; Haslam, Postmes, & Ellemers, 2003; Haslam, Turner, Oakes, Reynolds, & Doosje, 2002). Thus, the SIA can explain both the stable and dynamic influences of culture on depression expression. That is, while cultural representations or norms are characterized by stability over time, they are also context dependent, and hence potentially fluid. In this regard, they can be influenced by large-scale social changes that determine the frame of reference, and also by the specific intergroup attitude and ingroup goals that unfold in the immediate situation (Halloran & Kashima, 2006; Haslam, Turner, Oakes, McGarty, & Reynolds, 1997; Haslam et al., 2002).

However, cultural and social identity frameworks have seldom been integrated to understand *when* culture influences depression expression and more generally psychopathology. It is clear that the ideas and principles of the cultural frameworks (e.g., dynamic constructivist approach highlighting the importance of contextual cues in cultural influence) are quite similar to that of the SIA and to self-categorization theory in particular (see Verkuyten & Pouliasi, 2006, for similar argument). Yet, these complementary approaches have seldom been integrated despite holding promise in advancing our understanding on cultural influence. In the few studies examining this, Verkuyten and Pouliasi (2006) found that bicultural Greek participants living in the Netherlands when primed with either Dutch or Greek culture through iconic cultural symbols and language (i.e., Dutch or Greek cultural frames) would endorse perceptions and attitudes consistent with the activated or primed culture (e.g., describing themselves more frequently in Dutch or Greek stereotypical terms). Critically, cultural identification was found to mediate the relationship between cultural framing (i.e., Dutch or Greek cultural frames) and perceptions and attitudes. Not only does this suggest that cultural identification is an important psychological mechanism through which cultural framing can affect perceptions and behaviors, but also, that cultural identity salience can be important in affecting perceptions and behaviors. In a similar vein, Yip (2005) employed an experience sampling method and collected ethnic



identity salience ratings six times a day for a week. In this study, it was found that ethnic salience fluctuated across naturally occurring situations (i.e., varied within individuals across time); supporting the fluidity and dynamic nature of ethnic identity. More significantly, it was found that the extent to which individuals' ethnicity was salient when they were with family depended on ethnic centrality (i.e., the extent to which one makes ethnicity central to their overall social identity). What this suggests is that ethnic centrality can place ethnicity at the front of one's mind, thus increasing one's sensitivity to relevant situational cues (Yip, 2005).

Importantly, while there is value in considering social identity processes in explaining cultural influence, the role of cultural identity in culture priming and cultural contextual cues has not been thoroughly explored. Yet, linking social identity processes to cultural psychology offer the possibility of considering additional identity-related variables and processes; some of which are outlined next. For example, social identity researchers have frequently considered the nature of intergroup situation in identity processes (e.g., intergroup conflict, group threat, perceived compatibility of identities such as British and European identity; Cinnirella, 1997; Jetten et al., 2002; Livingstone & Haslam, 2008; Tajfel & Turner, 1979), and research has suggested identity processes (e.g., cultural identification) to be important in understanding cultural influence. This hints at the possibility of considering such intergroup processes in understanding the influence of culture or cultural identity, an area to be explored particularly with increasing globalization fostering multiculturalism and influencing intergroup relations (and possibly conflicts; Kinnvall, 2004; Rosenmann, Reese, & Cameron, 2016; Verkuyten & Pouliasi, 2006).

### **Social Identity Matters: Shared Identities Provide Identity Benefits and Resources**

From a SIA perspective, shared identities matter because they provide identity benefits and resources (Haslam et al., 2009; Jetten et al., 2015; Jetten, Haslam, Haslam, Dingle, & Jones, 2014). Indeed, groups provide us with something fundamental — they inform and support the self (Haslam et al., 2009; Jetten et al., 2015; Jetten et al., 2014). That is, they furnish us with a sense of belonging, purpose, meaning, grounding, and even “existential security” (Baumeister, 1986; Durkheim, 1951; Tajfel & Turner, 1979). Drawing on this theorizing, we are able to better understand the cultural underpinnings of depression in the following areas (a) why and when cultural identity motivates individuals to follow cultural norms, (b) why shared identity facilitates communication of depression in health contexts (leading to less reluctance to report psychological symptoms), and (c) how and why shared identities protect against developing depression. In other words, it is because of benefits and resources associated with shared identities that individuals are motivated to

adhere to cultural norms and also, communicate their depression in health contexts. These benefits and resources derived from shared identities can also help explain why identities protect individuals against developing depression.

**a. Norm Adherence.** As the SIA perspective argues, it is shared social identity that allows for social influence, whereby individuals become motivated to act in accordance with the salient normative content of group identity. One may then ask what it is about shared identity that motivates people to follow group norms (i.e., cultural norms), or why people would accept influence from other group members. The SIA's answer to such questions is that social identity matters (because it provides identity benefits and resources), and is therefore a source of motivation and agency (Ellemers, De Gilder, & Haslam, 2004; Oyserman & Destin, 2010). That is, the feeling of being part of something bigger and better helps us feel distinctive and special, enhances our sense of worth, and reduces our subjective uncertainty about the social world (Hogg, 2006). These identity consequences or benefits thus explain why individuals are motivated to engage in behaviors that are identity infused (e.g., behaviors that are congruent with their valued social identities, such as behaviors in line with cultural norms; Oyserman, 2007). The importance placed on self-identity is also highlighted in cultural research, whereby it is argued that individuals would engage in cultural practices repeatedly and earnestly to affirm their status as a cultural member of respectable standing in the eyes of the individuals themselves (i.e., cultural identities) and the community at large (i.e., reputations; Kitayama & Uskul, 2011).

Supporting the argument that identity matters, research has shown individuals identifying with the group to be motivated to display norm-consistent behaviors to express or affirm their identity, and to prove they belong to a certain group, particularly when individual's cultural self is threatened (Cheryan & Monin, 2005; Chiu & Hong, 2007; Chiu, Ng, & Au, 2013; Guendelman, Cheryan, & Monin, 2011; Jetten et al., 2002; Oyserman et al., 2007; Tarrant et al., 2011; Unger, 2011). For example, Guendelman et al. (2011) found Asian Americans to be more prototypically American in their food preferences (i.e., less healthy food) only when confronted with a threat to their American identity. Further demonstrating that identity matters (specifically with regards to identity helping to reduce uncertainty and to provide security), research has shown individuals to be motivated to follow cultural norms when experiencing a heightened need for epistemic or existential security (Chao et al., 2010; Halloran & Kashima, 2004; Kashima, Halloran, Yuki, & Kashima, 2004; Konic, Kruglanski, Pierro, & Mannetti, 2004). Consistent with the epistemic security notion, individuals with a chronic need for firm answers have been found to be particularly inclined to adhere to

cultural norms (Chao et al., 2010; Kosic et al., 2004). Halloran and Kashima (2004) also found that among Aboriginal Australian bicultural individuals, mortality salience increased adherence to Aboriginal values when the Aboriginal identity was primed, and adherence to Australian values when the Australian identity was primed. This suggests that identity consistent behavior buffers people against existential threats. Together, the evidence supports the argument that cultural identity matters as it fulfills basic social and psychological needs (i.e., provides benefits), and so in and of itself is motivating, leading to individuals identifying with their cultural groups and acting in line with norms. It is only by extending this to understand culture and depression expression then that we will be in a better position to examine not only why but also when cultural identity matters in *motivating* individuals to adhere to cultural norms (and express depression in a manner consistent with cultural norms).

The above literature suggests that key social identity principles and processes can be applied to understanding culture and depression expression. Specifically, we extend them to examine how and when Asian culture and its norms will affect depression expression (i.e., Asian somatization).

***Proposition 1.*** It is proposed that Asian norms influencing somatization (such as collectivism) will be associated with higher levels of reported somatic depression symptoms only when Asians identify more strongly with Asian culture.

**b. Communication of Depression in Health Contexts.** In culture and depression expression, a particularly interesting explanation proposed for Asian somatization is that it is a strategy to communicate distress to pursue or avoid particular outcomes (Choi, Chentsova-Dutton, & Parrott, 2016; Ryder & Chentsova-Dutton, 2012; Zhou et al., 2015). Here, it is argued that, due to the stigma associated with the direct expression of emotional difficulties, the reporting of somatic symptoms is perceived to be a more appropriate route for seeking help (Kleinman, 1982; Yang & Kleinman, 2008). In addition, Asians have been found to emphasize somatic symptoms of depression in medical settings but not when talking with family and friends (Cheung, 1995; Cheung & Lau, 1982). In another line of research on somatization in health contexts, researchers have found that somatic complaints were more common in both Asian and Western contexts when there was a lack of an ongoing relationship between a patient and a physician (Gureje, 2004; Simon, VonKorff, Piccinelli, Fullerton, & Ormel, 1999).

This literature taken together suggests that shared identity may be a critical factor in the expression of depression in health contexts. More specifically, this is because shared identity is associated with benefits such as trust and effective communication. Supporting this, research has shown perceived shared identity to promote trust (Foddy, Platow, & Yamagishi, 2009; Johnson et al., 2010; Tanis & Postmes, 2005) and self-disclosure (Dovidio et al., 1997). Accordingly, when the physician is perceived by the patient to be an in-group rather than an out-group member (i.e., understood to be “one of us,” and hence “we are in this together”), there may be more trust, alliance, and consequently self-disclosure (i.e., less reluctance to report psychological symptoms or less somatization; Cruwys et al., 2014). Also, a physician should have more access to richer client information to the extent that they share an identity, possibly because the patient is more willing and motivated to communicate (Haslam, 2004). Although the evidence suggests that shared identity may play an important role in facilitating communication, trust, and therapeutic alliance in health contexts (e.g., affecting the extent to which one somaticizes), little research has investigated this.

**c. Multiple Group Memberships and Resilience to Depression.** According to the social identity approach to health, belonging to multiple groups enhances wellbeing (e.g., protects against developing depression; Cruwys et al., 2014; Jetten et al., 2012). This is because shared group memberships (or shared identities) are psychological resources that individuals can draw on to contend with difficulties in their lives, promoting resilience and successful coping when encountering challenges or stressors (Haslam et al., 2009; Jetten et al., 2012; Jetten et al., 2014). More specifically, it posits that the more groups an individual belongs to, the more potential identity resources they have at their disposal. That is, they furnish individuals with a greater sense of belonging and purpose, and even provide more sources from which to draw social support in times of stress, in turn protecting and enhancing wellbeing (Haslam, Cruwys, Milne, Kan, & Haslam, 2015; Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009; Jetten et al., 2015; Tajfel & Turner, 1979).

Several studies have substantiated this claim by consistently showing multiple group memberships to be associated with greater wellbeing (Haslam et al., 2008; Iyer et al., 2009) and lower depressive symptoms (Cruwys et al., 2013). The beneficial effect of multiple group memberships has also been demonstrated experimentally by manipulating the psychological availability of group memberships (Jones & Jetten, 2011). In one study, participants who were asked to think of five group memberships (rather than one or three) performed better on a cold-pressor task (i.e., a task measuring resilience objectively); these participants submerged their hands for a longer time in icy water, indicating greater endurance.

Importantly, although much of the empirical work on multiple group membership and wellbeing has generated important insights, these studies have focused primarily on Western participants. It therefore remains to be examined whether the findings generalize to Asian cultures. Given that studies on culture and social support have suggested that cultural norms about relationships in the Asian cultures could make Asians more sensitive to the negative relational consequences of support seeking when compared to European Americans (e.g., burdening others, disrupting group harmony; Kim, Sherman, & Taylor, 2008; Taylor et al., 2004), there are good reasons to believe that such findings may not easily generalize to Asian populations. That is, Asian cultural norms may affect the degree to which Asians feel it is appropriate to draw upon support resources derived from shared group memberships. This would in turn influence how likely they utilize their group membership support resources, and consequently, their wellbeing and resilience to depression. This reasoning is captured in a second proposition.

***Proposition 2.*** It is proposed that multiple group memberships will confer fewer wellbeing and resilience benefits for Asians, relative to Westerners. This is expected to be due, in part, to Asian cultural norms which make Asians more reluctant to tap into social support resources from their group memberships.

### **Social Norms Matter: The Role of Shared Identity in the Development and Communication of Consensual Representations**

What should be obvious from the previous sections is that group consensual representation (i.e., collective-level product) plays an important role in the SIA, and the reasoning is similar to that of a norm-based approach to characterizing culture (Chiu et al., 2010; Morris et al., 2015). Specifically, such shared perceptions of reality within the group are fundamental in the SIA because they are the property of culture; they are what constrain and influence the action of individuals (Turner, 1991). Importantly then, given that it is a collective product, what are the *group-level* processes by which such consensus is reached? Why or when would individuals be motivated to participate actively in the creation and communication of such representations? How do individual-level perceptions come to be collectively shared and have the power to influence behavior? These questions have been studied by social identity researchers in the last few decades. This is reflected in frameworks on shared identity and stereotype consensus (e.g., group consensualization process; Haslam, Oakes, Reynolds, & Turner, 1999; Haslam et al., 1997), shared identity and communication

(Haslam, 2004; Morton, Wright, Peters, Reynolds, & Haslam, 2012), and the interplay between individuals and groups (e.g., collective products; Postmes et al., 2005a; Postmes & Jetten, 2006), which are briefly outlined next.

It is argued in SIA that group consensual representations do not arise spontaneously from any social interaction. The SIA specifies that only interactions in the context of a shared identity have the capacity to shape collective perceptions, attitudes, and norms (e.g., content of identity; Brewer, 2001; Postmes et al., 2005a). This is because shared identity is what motivates individuals to strive actively to reach a consensual representation (Haslam et al., 1997; Haslam et al., 2002; Reicher, Hopkins, & Condor, 1997). In line with this reasoning, a series of studies has demonstrated that when social identification is salient, there is more collective consensus on what the shared beliefs of the group are (Haslam et al., 1999; Haslam et al., 1997; Haslam et al., 1998). Specifically, it was found that when the Australian identity of participants (compared with personal identity) was made salient, participants were more likely to articulate a shared view of Australians (i.e., traits most typical of Australians; Haslam et al., 1999). Overall then, the ability to think in terms of “we” and “us” (i.e., identification) is what enables individuals to engage in meaningful and collaborative behavior, and contribute to shared representations (Haslam et al., 2002; Turner, 1982). Critically too, it is this process of group consensualization whereby individuals’ perceptions come to be validated and shared by others, thus transforming individuals’ potentially idiosyncratic views into shared beliefs, that makes them extremely socially potent (Jetten & Haslam, 2016; Smith & Postmes, 2010). Socially shared views have particular force because, in the process, personal opinions are turned into objective social fact (Bar-Tal, 1998; Hardin & Higgins, 1996; Haslam et al., 1997). Accordingly then, “I think it is important to be collectivistic” becomes “it is important to be collectivistic”.

Key to understanding the process of group consensualization is the work on shared identity and communication (see Haslam, 2004; Postmes, 2003, for reviews). In this work, it is argued that shared identity provides individuals with a shared reality (i.e., group consensual representation) and multiple motivations for communicating. Accordingly, communication with people with whom we share identity should be easier, and more fluent, effective, and productive (Greenaway, Wright, Willingham, Reynolds, & Haslam, 2015; Morton et al., 2012; Peters, Morton, & Haslam, 2010). Indeed, a body of empirical work has shown that a sense of shared identity can make people (a) more willing and motivated to communicate with each other (e.g., greater desire to pass on information; Haslam, 2004), (b) more inclined to adjust their behaviors in ways that meet others’ expectations (e.g., align their communication with

others, use specific communication codes; Bourhis, 1991), (c) more open to others' communication (e.g., pay more attention to messages, find messages to be more persuasive; Kane, 2010; Mackie, Worth, & Asuncion, 1990; McGarty, Haslam, Hutchison, & Turner, 1994; Wilder, 1990), and (d) more likely to interpret communicative acts in similar ways because of a shared way of thinking (e.g., in the spirit in which they are intended; Haslam, 2004; Postmes, 2003).

In short, the SIA postulates that shared identity promotes motivation to effectively communicate group representations to other group members in everyday life, and it is through the process of group consensualization that such representations become socially potent. This highlights the power of group representations, and the importance of examining them in the influence of culture on depression expression.

Similar to the SIA, cultural research has also emphasized the epistemic and communication functions of group consensual representations (Chiu et al., 2010). First, it is argued that these representations offer consensual validity and interpretative authority (because they are widely shared and accepted). Notably, the importance of socially shared nature of representations is highlighted in both cultural and social identity approaches. Specifically, cultural research has shown individuals to identify more strongly with their culture and conform to cultural expectations more upon learning that their goals are widely shared (Zhang & Chiu, 2012). Along these lines, social identity research has demonstrated the reciprocal influence of social identification and social validation (i.e., the provision of a subjectively beneficial view of the world; Postmes, Spears, Lee, & Novak, 2005b). Second, cultural approaches contend that individuals tend to use shared cultural representations to establish common ground with conversation partners, and in so doing, perpetuate these perceptions and their shared nature, explaining why well-known cultural ideas and practices maintain prominence (Chiu et al., 2010; Zou et al., 2010). Supporting these ideas, research has showed individuals to be more inclined to include shared (compared to idiosyncratic) knowledge in communicative messages (Lau, Chiu, & Hong, 2001). This is further substantiated by Kashima et al. (2008) who found that individuals framed their messages in terms of constructs from the shared cultural tradition when facing an ingroup audience. More significantly still, information consistent with consensual representations has been found to often perpetuate through information transmission, while inconsistent information tended to drop out in the process (Kashima, 2000).

What remains underspecified in cultural approaches, however, is the role of shared identity and accordingly, social influence. As outlined in this section, it is through

considering these mechanisms that we can understand how and when cultural representations become consensual and socially potent. Critically, in the consensualization process, there is a clear recognition of the interaction between the individual and the social, and the processes by which they mutually constitute each other (Postmes & Jetten, 2006; Postmes et al., 2005b). Such SIA theorizing can in fact benefit sociocultural approaches to comprehensively elucidate the processes underlying a person-situation interaction perspective on culture. That is, it puts us in a better position to understand this mutual influence, whereby (a) communication among cultural members can produce, and is produced by, a shared framework, and that (b) individuals (e.g., behaviors, identities) are shaped and influenced by cultural norms, but at the same time, cultural norms are actively contested, discussed, and shaped by individuals (Haslam, 2004; Postmes & Jetten, 2006).

Furthermore, the SIA sheds light on why individuals are motivated to establish common ground with conversation partners, and (as also highlighted in cultural approaches) use shared representation to achieve this. In the SIA conceptualization, this is because of motivations derived from sharing an identity, prompting individuals to align their communication with others so as to convey their messages effectively (e.g., use shared representations to reach common ground, customize communicative messages and communication styles to the preferred mode and style of communication of others). After all, it is only when individuals define themselves in terms of “we” that their motivations and attempts to communicate lead to a full transfer of information and meaning (Haslam, 2004). It is also these consequences flowing from shared identity (e.g., motivation to align conversation with others, shared way of thinking leading to communicative acts interpreted in similar ways) that can help explain why information consistent with shared cultural representations is transmitted and perpetuated efficiently.

Therefore, it is key to integrate these approaches to provide a more comprehensive understanding of shared cultural representations in depression expression, such as the development and maintenance of these representations. Here, it is worth noting that shared cultural representations can shift. This is because as noted above, in the SIA, group consensualization is dynamically influenced both by the particular intergroup attitude and ingroup goals that unfold in the immediate situation, and by large-scale social changes (Halloran & Kashima, 2006; Haslam et al., 1997; Haslam et al., 2002). Extending this to understand culture and depression expression can offer insights on how cultural patterns change. For example, we can better comprehend the reduced emphasis on somatic over psychological symptoms in Asian cultures with globalization (i.e., influence of Western



values and cultural content on presentation of depression in Asian cultures; Rao et al., 2007; Ryder, Sun, Zhu, Yao, & Chentsova-Dutton, 2012), an underexplored but important area in culture and depression expression.

All in all, the SIA highlights the importance of examining group consensual representations — such representations are communicated and transmitted effectively, and are extremely socially potent, among group members. Applying this reasoning to *collective-level* cultural factors (rather than individual-level factors) that influence vulnerability to depression in Westerners, we examine the effects of communicating happiness and unhappiness norms (i.e., that happiness is desirable and unhappiness is undesirable) on depression in Asian and Western contexts. This leads to the third proposition.

**Proposition 3.** It is proposed that social norms espousing the importance of happiness and the undesirability of unhappiness will be more detrimental to the wellbeing of Westerners, relative to Asians' wellbeing.

### Summary and Implications

Through this analysis, we have highlighted the importance of a dynamic and coherent theoretical framework to comprehensively understand how, when, and why culture influences depression expression. More importantly, we have argued that the SIA adds value to understanding these processes, and we have outlined a few key principles and processes. In particular, the SIA provides a broad coherent framework that takes into account the stable yet dynamic nature of cultural normative expectations and identity. This helps to understand specific mechanisms by which culture shapes depression expression. In addition, the SIA is able to accommodate a central place for the self and other (i.e., culture), and explains which particular “others” will shape what “our” norms are, and the extent to which they are reflected in depression expression (i.e., cultural identification; Hogg & Reid, 2006; Postmes, Akkus, & Stroebe, 2015; Terry & Hogg, 1996). This is not just exciting from a theoretical point of view, but such theorizing can be used to guide clinical practice. That said, much of the supportive evidence for the use of SIA in understanding culture and depression expression is indirect. In other words, although the processes and mechanisms that have been described are plausible, and grounded in research, many of them have not been tested empirically in the area of culture and depression expression.

It is worth noting too that there is an inherently complementary nature of the cultural perspective and the social identity perspective. Indeed, it is precisely this compatibility that

enables us to draw from these different approaches, thereby offering the necessary theorizing needed to comprehend the cultural underpinnings of depression expression. First, both perspectives emphasize the social nature of self-concept, whereby others (i.e., social groups or culture) can impact on self-conception and social behavior (Markus & Kitayama, 1991; Oyserman, 2007; Turner, 1982). However, while the social identity perspective has focused on understanding when social identities are a salient part of self-concept and when they are not, cultural perspective has concentrated on cultural differences in the likelihood that the self is personal or social in focus (i.e., independent or interdependent self-construal; Markus & Kitayama, 1991; Oyserman, 2007). Another similarity is that in understanding cultural influence, both perspectives recognize the importance of considering cultural normative expectations and the context-dependent nature of cultural influence. Drawing on the SIA can help provide a sound analysis of cultural normative expectations (such as explaining normative influence) and the context-dependent nature of cultural influence. In this regard, the SIA offers the theoretical framework and means to develop an analysis of process to understand the relationship between culture and depression expression. It in fact provides a parsimonious framework for conceptualizing the role of culture in depression. Just to name a few, it is able to account for normative influence, within-culture variation, the context-dependent nature of cultural influence, the socially potent nature of cultural norms, and the development and maintenance of cultural norms. For these reasons, it is particularly surprising that — given their complementary theoretical assumptions — the cultural perspective and the social identity perspective have seldom been integrated (Hong, 2009; Oyserman, 2007).

Specifically here, two complementary approaches (i.e., social identity and cultural approaches) have been integrated to provide a sophisticated understanding of the cultural underpinnings of depression expression (i.e., clinical psychology). Bringing together theoretical work from a range of fields can open new avenues of research. Specifically, we can, (a) apply social identity principles to understand cultural influence and its relevance to depression expression (e.g., motivations to adhere to, and communicate, depression expression cultural norms), (b) relate cultural principles to understand depression expression (particularly the dynamic nature of cultural influence), and (c) apply social identity principles to understand depression expression (i.e., shared identity in the communication of depression in health contexts). Importantly, though the SIA has been applied to understand culture and depression, this might however serve as a model for how researchers might study psychopathology in other cultural contexts.

## Thesis Overview

Overall, how, when, and why culture shapes depression expression has not been explored in great detail. Taking a social identity perspective, we aim to advance research on understanding ways in which depression is culturally shaped in three lines of research that target (a) the symptomatic presentation of depression (Proposition 1), (b) cultural factors associated with resilience (Proposition 2), and (c) vulnerability, to depression (Proposition 3, see Figure 1). In focusing on the circumstances in which culture shapes depression expression, the research moves beyond describing (e.g., classification of cultural group differences in symptomatic presentation of depression) to explaining cultural group variations (e.g., identifying processes and mechanisms underlying cultural differences). To this end, a series of studies were conducted. All were prepared as manuscripts for submission to peer-review psychological journals. They form the empirical chapters of this thesis (Chapters 2 to 5). In each of these chapters, the literature on the specific topic will first be reviewed, followed by a write-up of the studies and discussion of the studies' key findings.

Chapter 2 extends the key social identity principles and processes detailed here to understand the impact of culture on the symptomatic and clinical presentation of depression — an area of culture and psychopathology that has received perhaps the greatest attention. More specifically, this work has focused on Asians' tendency to emphasize somatic symptoms of depression over psychological symptoms (Kleinman, 1982; Marsella, 1980; Ryder et al., 2008). Despite extensive investigation of somatization of depression (e.g., Dere et al., 2013; Ryder et al., 2008; Simon et al., 1999; Yen, Robins, & Lin, 2000), much of this work has perhaps focused too strongly on the question of whether Asians somatize. Comparatively, there has been little theoretical progress explaining *when* and *how* culture affects the expression of depression. It is proposed that social identity theorizing (Tajfel & Turner, 1979; Turner, 1991) can fill this gap by explaining when and how culture and its normative expectations affect depression expression. Therefore, as the first line of research, we investigate the role of cultural identity on the expression of depression (i.e., somatization of depression) across three studies. More specifically, we examine the prediction that cultural norm would influence depression expression only when individuals *identify* with their culture (Proposition 1). On the basis of previous research, two cultural norms were the focus of attention: mental illness as culturally stigmatized and collectivism as a cultural norm.

The second line of research focuses on an arguably neglected area of research — depression, or rather vulnerability to depression, in Western cultures. In studies understanding the role of culture in depression expression, there is a tendency to

conceptualize the Western perspective as the frame of reference or norm. Within the Western framework, the emphasis on psychological symptoms and direct expression of feelings is often assumed to constitute the norm for depression. In contrast, somatization is commonly viewed as dysfunctional in Western cultural contexts (Allen, Gara, Escobar, Waitzkin, & Silver, 2001; Keyes & Ryff, 2003), whereby Asians and their emphasis on somaticizing depression is often portrayed as “what needs to be explained”. This possibly explains why Asian somatization has primarily attracted attention in contrast with the supposed Western emphasis on psychological symptoms (i.e., what could be called Western psychologization). Critically though, it has been argued that if anything, samples drawn from Western societies are apparently unusual compared with the rest of the human species (i.e., least representative populations for generalizing about humans; Henrich, Heine, & Norenzayan, 2010). More importantly, our understanding of the relationship between culture and depression is at best incomplete if only Asian somatization is examined.

With this in mind, in Chapters 3 and 4, we shift attention to studying depression in Western cultures. This is in line with recent work contending that the very concept of somatization rests on the cultural assumption that psychological symptoms are more central to depression, and has thus focused on Western psychologization (Dere et al., 2013; Ryder & Chentsova-Dutton, 2012; Ryder et al., 2008). More specifically, this research has suggested that psychologization among Westerners represents the larger and more consistent effect, raising the possibility that this may be more culturally specific than Asian somatization (Ryder et al., 2008). Along these lines, a growing body of work finds evidence that the Western emphasis on the pursuit of happiness (and avoidance of unhappiness) may rather ironically create a vulnerability to depression (Ford et al., 2014; Mauss et al., 2012; Mauss et al., 2011). However, though important, the social and cultural contexts reinforcing such messages regarding the value of happiness and unhappiness tend to be overlooked in the literature (i.e., perceptions of how others within the social environment value and approve happiness and unhappiness; Bastian, 2013). Put simply, it may be hard to ignore the value of happiness if it is viewed as appropriate and normative by society, and constantly reinforced through salient cultural reminders (e.g., refrains of “don’t worry, be happy!”, American Declaration of Independence listing the pursuit of happiness as a fundamental right; Bastian, 2013; Tsai, Louie, Chen, & Uchida, 2007). Expanding on this, the second line of research adopts a social identity perspective of social influence (Hogg & Reid, 2006; Turner, 1991) and assumes a norm-based approach to characterizing cultural influence to examine specific *collective-level* cultural factors that are associated with vulnerability to depression among

Westerners. Specifically, we seek to understand the effects of collective-level (as opposed to individual-level) motivations to pursue happiness and avoid unhappiness (i.e., cultural normative expectations regarding happiness and unhappiness) on one's emotional functioning (i.e., depression, wellbeing) in Asian and Western contexts. The study in Chapter 3 examines whether and why salient social norms regarding the value of happiness (that happiness is desirable) have the potential to make individuals feel worse (Proposition 3). We also examine if there are cross-cultural differences in these effects. On the basis of previous research, it is predicted that happiness norms may be more strongly associated with higher depressive symptoms and reduced wellbeing in Western than in Asian contexts. Additionally, to provide evidence supporting the socially potent nature of cultural normative expectations, we examine in Chapter 4 social norms regarding the value of unhappiness (that unhappiness is undesirable) as a potential mechanism underlying why negative emotions may be more impactful on the wellbeing (e.g., depression) of Westerners, relative to Asians (Proposition 3).

In a final line of research, we examine specific cultural protective factors for depression and wellbeing (Chapter 5). A particularly powerful predictor of wellbeing that has been identified in the social identity literature is multiple group memberships (Cruwys et al., 2013; Cruwys et al., 2014; Haslam et al., 2008; Jetten et al., 2015; Jetten et al., 2012). However, as noted above, much of the empirical work on multiple group membership and wellbeing has been conducted primarily in Western societies. Furthermore, there are good reasons to believe that the multiple group membership effect may not easily generalize to Asian populations. Addressing this issue, the third line of research investigates the role of multiple group memberships in Asian and Western contexts across four studies. Specifically, we seek to examine whether cultures differ in, (1) the ease to which individuals draw on social support resources from multiple group memberships, and (2) the extent to which these memberships are associated with wellbeing and resilience to depression (Proposition 2).

The key findings across the nine studies are reviewed and synthesized in the final chapter that provides a broad conclusion from the present work. Here, we discuss the evidence supporting the three propositions and highlight the utility of social identity related processes and mechanisms to explain the cultural underpinnings of depression expression.

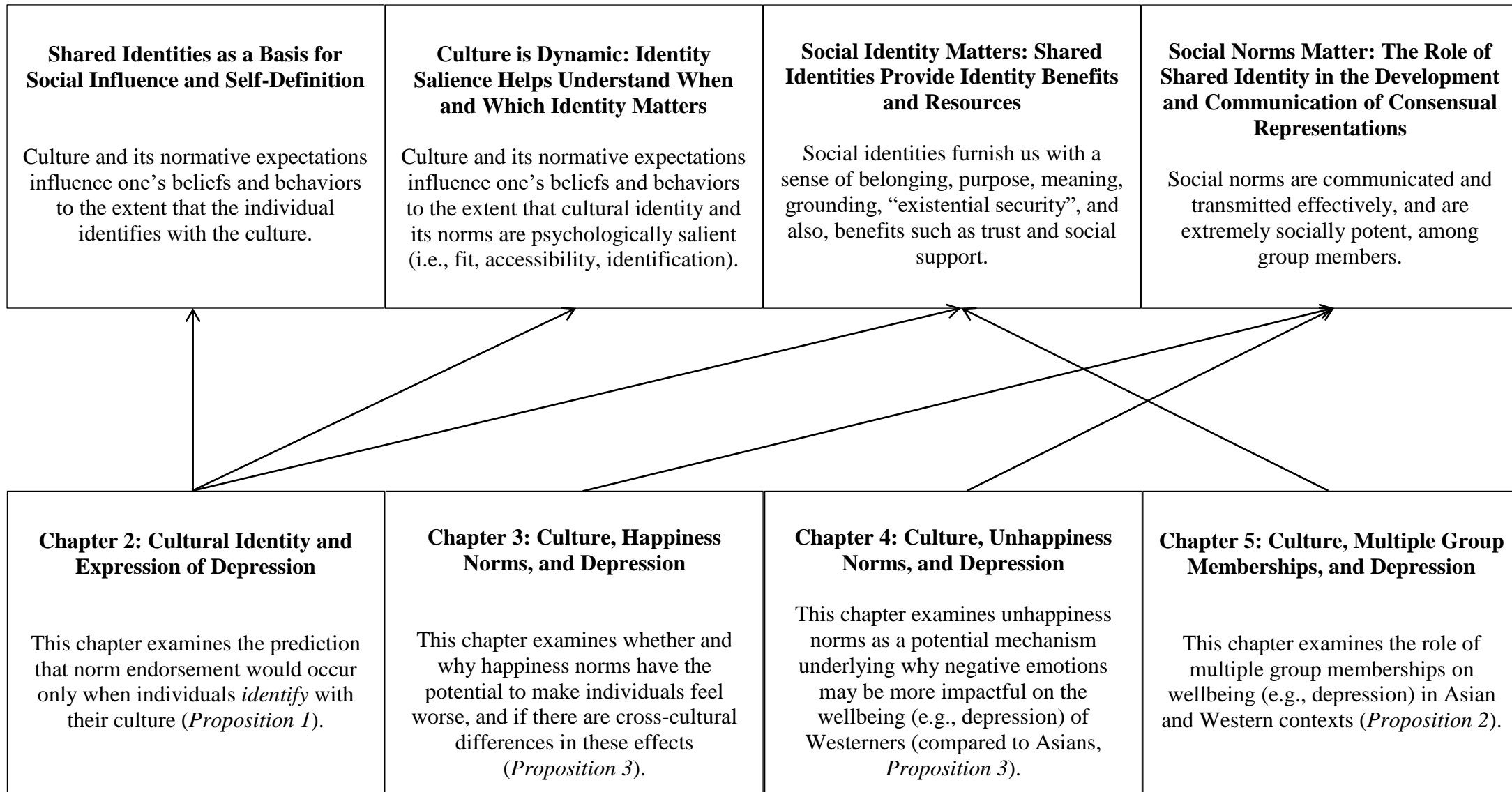


Figure 1. Understanding depression across cultures: A Social Identity Perspective.

## Chapter 2: Cultural Identity and the Expression of Depression: A Social Identity Perspective<sup>3</sup>

### Abstract

The present research interrogates the greater tendency for Chinese people to somaticize depression relative to Westerners. Drawing from a social identity perspective, three studies were conducted examining the role that cultural norms play in symptom expression. In an initial study, we confirmed greater somatization, minimization of distress, and suppression of emotional expression among Chinese participants compared to Australians (Study 1). Asian normative expectations of collectivism moderated these effects such that somatization was higher among those who endorsed collectivism norms, but only among Chinese participants. Studies 2a and 2b found that only when Asian participants identified strongly with Asian culture did collectivism norms predict somatic symptoms. These findings have implications for practitioners working with people from Asian cultures, highlighting that it is not culture per se, but the endorsement of normative expectations in the context of strong identification with cultural groups that predicts which symptoms of depression are emphasized.

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<sup>3</sup> As most research on cross-cultural differences in depression (i.e., Asian somatization) has focused on Chinese samples, we examined primarily Chinese somatization in this chapter.

### **Cultural Identity and the Expression of Depression: A Social Identity Perspective**

There has been considerable interest in cultural differences associated with the expression and presentation of psychopathology, and depression in particular. Much of this work has focused on Chinese people's tendency to emphasize somatic symptoms of depression (i.e., lack of sleep, poor appetite, headaches) over psychological symptoms (i.e., feeling sad, worthlessness; Kleinman, 1982; Marsella, 1980; Ryder et al., 2008). Despite extensive investigation of Chinese somatization (e.g., Ryder et al., 2008; Simon, VonKorff, Piccinelli, Fullerton, & Ormel, 1999; Yen, Robins, & Lin, 2000), there has been little theoretical progress explaining when and how culture affects the expression of depression. We argue that social identity theorizing (Tajfel & Turner, 1979; Turner, 1991) can fill this gap by explaining *when* culture and its normative expectations affect depression expression. According to this theoretical framework, being a member of a particular culture does not automatically result in normative cultural behavior (e.g., somatization). Rather, increased somatic symptom expression should occur when a person is more sensitive to, and willing to endorse, cultural norms and scripts — a process that is underpinned by the extent to which an individual *identifies* with the culture. That is, cultural norms will be related to somatization, particularly among those who identify strongly with the culture. We test this hypothesis in three studies examining the role of cultural identity on depression expression.

#### **Culture and the Somatization of Depression**

The empirical literature on Chinese somatization is mixed. On the one hand, numerous studies have shown that, relative to Westerners, Chinese people are more likely to express depression in somatic rather than psychological terms (Kleinman, 1982; Parker, Cheah, & Roy, 2001a; Ryder, et al., 2008). For instance, a study conducted by Parker et al. (2001a) with depressed patients showed that a substantial majority of Chinese Malaysian patients (60%) reported a somatic symptom as their chief complaint compared with a small minority of Australian patients (13%). Similarly, a comparison study found that Chinese depressed patients were significantly more likely to report somatic symptoms on unstructured and structured interviews than North American patients (Ryder et al., 2008).

However, there have also been many studies that fail to find support for this relationship (Cheung, 1982). For example, in a cross-cultural study by Simon et al. (1999), it was found that somatic presentation of depression seemed to vary little from one country to another. Furthermore, in one of the few cross-group comparison studies, Yen et al. (2000) found that a Chinese student sample reported significantly fewer somatic symptoms compared with an American student sample.



These inconsistent findings raise doubts about current understanding of the influence of culture on depression expression, and point to the importance of identifying the conditions under which Asians might emphasize somatic symptoms.

### **Why do Chinese People Emphasize Somatic Symptoms?**

Various cultural normative explanations have been proposed to explain why Chinese people somaticize more than people in the West. The most developed of these suggests that in Chinese culture, mental illness is often viewed as a weakness of character and a cause of family shame (Mak & Chen, 2010; Parker, Gladstone, & Chee, 2001b). Consistent with this reasoning, several studies have shown that stigma associated with depression is more severe among Asians than Caucasian Americans (Chan & Parker, 2004; Chung & Wong, 2004; Hsu et al., 2008). As a result, mental illness is more stigmatized among Chinese people compared to Westerners, and this may explain why Chinese people resort to describing their symptoms in ways that avert attention away from potential indicators of mental illness (Ryder, Bean, & Dion, 2000). According to this account, Chinese people somaticize because it allows those who are depressed to inhabit the sick role in their societies without bearing the burden of stigma (Goldberg & Bridges, 1988). Here, we focus on stigma as a cultural norm (Coker, 2005), and examine whether cultural differences in the normative endorsement of mental illness stigma account for the way depression is expressed in Asian and Western cultures.

Stigma related concepts such as “face” concerns or “*mianzi*” have also been argued to be important in understanding Chinese somatization (Mak & Chen, 2010; Zaroff, Davis, Chio, & Madhavan, 2012). Research has identified preserving “face” to be a key interpersonal dynamics in Asian cultures (Bond, 1991). Furthermore, concerns of “face” loss have been found to predict more negative attitudes towards seeking help from mental health services among Asians (Leong, Kim, & Gupta, 2011). Hence, researchers argue that Chinese people may somaticize to preserve “face” because mental illness is particularly stigmatized in Chinese culture (Zaroff et al., 2012).

Other researchers have focused on the role of collectivism. In particular, they have argued that in order to preserve relationship harmony, collectivistic Asians somaticize because suppression of emotion is culturally expected (Zaroff et al., 2012). In other words, in Asian culture, collectivism may be normatively emphasized; prescribing individuals to moderate or suppress open expression of negative emotion (Heine, Lehman, Markus, & Kitayama, 1999; Matsumoto et al., 2008), including depression related symptomatology. Here (as we do for stigma), we conceive of collectivism as a cultural norm. This operationalization is consistent with previous research demonstrating that individualism

versus collectivism can function as a collective attribute or norm (Jetten, Postmes, & McAuliffe, 2002).

These predictions in relation to the role of stigma and collectivism as *cultural norms* accounting for normative processes involved in Chinese somatization have rarely been tested empirically. Overall then, it is not clear when and how culture and its normative expectations influence behavior. As the mixed research findings suggest, cultural expectations do not always guide the expression of depression symptoms — at times, Chinese people somaticize and at other times they do not. The lack of theoretical progress on this issue is concerning in light of the fact that failure to correctly detect and diagnose depression increases the risk of inadequate or inappropriate treatment (Comino, Silove, Manicavasagar, Harris, & Harris, 2001; Hwang, Myers, Abe-Kim, & Ting, 2008). To disentangle the mixed findings and better understand the processes and conditions under which cultural norms will influence depression expression, we turn to social identity theorizing.

### **Understanding Cultural Variation in Psychopathology: A Social Identity Perspective**

A central premise of the social identity approach (SIA; Tajfel, 1978; Tajfel & Turner, 1979; Turner, Oakes, Haslam, & McGarty, 1994) is that social group membership informs our self-understanding. The principles and values that come to define us as individuals (e.g., who we are and what we do) are ones that we derive from the social groups to which we belong (i.e., social identification). Moreover, along with group membership comes knowledge of the characteristics that define the group and the norms that it values (e.g., collectivism in Chinese culture; Turner et al., 1994). When a person self-categorizes in terms of a particular group membership, the individual incorporates the group's defining values and characteristics (or group norms). Endorsing these group norms and acting in accordance with them signal one's affiliation to, and inclusion in, the group (Hogg & Turner, 1987; Louis, Taylor, & Douglas, 2005; Turner et al., 1994). This reasoning suggests that normative behavior (or norm adherence) is a product of social identification — an indication that the individual has taken on the identity as an important part of self (Turner & Oakes, 1989).

We argue that the SIA can help to understand the cultural underpinnings of depression. Culture can be conceptualized as a specific social identity that encompasses characteristics that define the group (i.e., cultural expectations; Wan, Dach-Gruschow, No, & Hong, 2010). Drawing on social identity theorizing, we argue that identification with a cultural group (i.e., cultural identification) will be associated with greater endorsement of normative expectations (the content of a cultural identity), and, in turn, this will guide one's behavior in social contexts (e.g., as in the expression of depression; Chang & Jetten, 2015). Whether or not

culture and its norms influence depression expression is therefore dependent on the extent to which the individual *identifies* with the culture. That is, social identification makes social influence possible (Turner, 1991). It is only when people identify with the culture that the normative expectations associated with that culture have the power to influence individuals, motivating them to act in accordance with normative expectations. This reasoning has been substantiated by previous research showing that individuals who identify strongly with their culture behave in ways that are consistent with the normative characteristics of the group (e.g., Heaven, 1999; Jetten et al., 2002).

This theorizing also helps to explain why there is variation in the extent to which members of a cultural group identify with and thus endorse the group's norms. Indeed, mere belonging to a particular cultural group (i.e., a demarcated population as defined with respects to certain geographic or ethnic characteristics) does not imply that one will endorse and act in accordance with the normative expectations of that group (Hong, Wan, No, & Chiu, 2007; Spiro, 1992). Rather, individuals are active agents who negotiate and at times defy normative expectations (Jetten & Hornsey, 2014). As such, individuals may either reject normative characteristics of the culture or selectively identify with that part of the culture that suits them (Wan et al., 2010).

In recent years, two other conceptual frameworks proposed to understand the influence of culture and psychopathology have emerged — the Cultural Influences on Mental Health Model (CIMH; Hwang et al., 2008) and the Culturally Informed Illness Representation Self-regulation Model (CIRSRM; Wong, Tran, Kim, Van Horn Kerne, & Calfa, 2010). Both frameworks recognize the importance of cultural norms in shaping psychopathology. However, unlike the SIA, these frameworks do not predict when culture will lead to somatization because they treat culture as a somewhat stable “in-the-head” trait, rather than a dynamic state that can vary as a function of social identification. Put differently, they predict that cultural knowledge is chronically salient and has a constant influence on one's beliefs and behaviors. In contrast, the SIA predicts that cultural knowledge and/or cultural expectations are more likely to guide beliefs and behaviors to the extent that a person (a) endorses cultural norms and (b) identifies with the culture (and thus with the normative content of that culture). In that sense, SIA offers a more dynamic theoretical framework to explain the conditions under which culture affects depression expression. In the following studies, we test this reasoning.

## Overview of Studies

Across three studies, we investigated the role of cultural identity on the expression of depression. Drawing on the SIA, our key prediction is that the interaction between strength of identification with one's culture and endorsement of its norms is what drives expression of depressive symptomatology. More specifically, we predict that norm endorsement would occur only when individuals *identify* with their culture. On the basis of previous research, we focused on two cultural norms: the endorsement of, mental illness as culturally stigmatized and, collectivism as a cultural norm.

Unpacking the key prediction, the aim of the first study was twofold. First, we aimed to replicate the finding that somatization is higher among Asians than Westerners (H1). Given the literature suggesting that somatization may be part of a broader pattern of behavior in which Chinese people may suppress emotional expression and minimize depression symptoms (i.e., by denying problems; Conrad & Pacquiao, 2005; Gross & John, 2003), we extended the investigation to examine other theorized cross-cultural variations in depression expression to develop a holistic understanding of the communication of depression symptoms in different cultural contexts. To this end, we measured the tendency to minimize symptoms of distress and to suppress the expression of emotions, in addition to somatization. It was predicted that Asians would minimize symptoms of distress (H2), and suppress the expression of emotions (H3), relative to Westerners. Second, in Study 1, we hypothesized that cultural differences in the reporting of depression symptoms (i.e., somatization) would be moderated by cultural normative expectations (H4, H5). Lastly, in Studies 2a and 2b, we tested whether strength of identification with one's culture would moderate the effect of cultural normative expectations on somatic symptom expression (H6, H7).

### Study 1

In Study 1, among Chinese and Australian participants, we examined whether Asians tended to somaticize, minimize symptoms of distress, and suppress emotional expression relative to Westerners in the communication of depression symptoms. A second goal of Study 1 was to investigate whether differences between Asians and Westerners in the reporting of depression symptoms are moderated by cultural normative expectations (i.e., stigma and collectivism norms). Drawing on the SIA, we did not predict a relationship between endorsement of stigma and/or collectivism norms and somatization among Australian Westerners because we did not expect the content of Australian cultural identity to be relevant to the somatization of depression symptoms. However, because culture provides a guiding framework for meaning among Chinese participants (Chang, 2000), we predicted that

in the process of communicating depression, Chinese participants would report more somatic symptoms and fewer psychological symptoms of depression (H1), minimize symptoms of distress (H2), and suppress the expression of emotions (H3), relative to Australian participants. In addition, it was predicted that normative expectations of stigma (H4) and the endorsement of collectivism (H5) would moderate the effect of culture on somatization, such that somatization would be higher only among Chinese participants who endorsed stigmatized perceptions of mental illness or collectivism.

## Method

**Participants.** Participants were 66 undergraduate students at a large Australian university; 37 international students who were born and raised in Asia and described their ethnicity as Chinese (11 males, 26 females), and 29 Australian Caucasians (11 males, 18 females). Participants were recruited from a psychology research pool and either received course credit or \$10 for their participation. Chinese participants ( $n = 37$ ) were on average 23 years old ( $SD = 2.74$ ) and the average length of time spent in Australia was 21.05 months. Australian participants ( $n = 29$ ) were on average 19.4 years old ( $SD = 2.68$ ).

## Procedures and Measures

Ethical clearance for all studies was provided by the Psychology Ethics committee at the University of Queensland. In all studies, participants ticked a box before starting the survey, indicating their informed consent. Additionally, the measures administered in all studies were in English.

A vignette, previously used by Wong and colleagues (Wong et al., 2010), was adapted to describe symptoms consistent with the diagnosis of major depressive disorder as defined by the DSM-5 (American Psychiatric Association, 2013), and the depression symptoms described in the vignette included both somatic and psychological symptoms. Participants were asked to imagine that they experienced the following problem in their lives:

*“Imagine, for the past month, you have felt that something is wrong with your life. You feel intense sadness and fatigue throughout the day. You find it very hard to get out of bed, go to university, or do anything. You have lost interest in many things that you usually enjoy. During this time, you have great difficulty sleeping despite feeling tired and often you do not feel like eating. In addition, you experience difficulty concentrating and increasing feelings of worthlessness. Because of these experiences, you have difficulty functioning in important areas of your life.”*

After reading this, participants were asked a free-response question:

*“Now, you decide to see a GP (Medical doctor/General Practitioner) in Australia about your problems. Your GP says “Tell me what brought you here today?” Please write down what you would say to your GP.”* Responses were blind-coded for somatization, minimization of distress, and emotional suppression (Coding scheme is elaborated below).

**Collectivist Values.** Participants were presented with 7 statements that were adapted from the Asian American Values Scale – Multidimensional (AAVS-M; Kim, Li, & Ng, 2005). These statements were said to “describe individuals in your culture” and participants were asked to indicate to what extent they agreed with the statements on a 7-point scale (1=*Strongly disagree*, 7=*Strongly agree*). An example item is “One’s personal needs should be second to the needs of the group” ( $\alpha = .82$ ).

**Perceived Stigma.** Four items were developed to measure the perception of stigma as a cultural norm (e.g., “In Asian cultures, people distance themselves from individuals with mental illness”;  $\alpha = .92$ )<sup>1</sup>. Each item was rated on a 7-point scale (1=*Strongly disagree*, 7=*Strongly agree*).

## Results

**Symptom Coding.** In the case of *somatization*, responses were coded for emphasis, rather than exclusive presentation of one set of symptoms, on a 3-point scale. This is because many researchers have argued that the experience of depression includes both somatic and psychological symptoms for Chinese and Westerners, albeit differentially, and it is rare for individuals in either group to solely report one set of symptoms (somatic or psychological; Mak & Zane, 2004; Ryder & Chentsova-Dutton, 2012).

A code of 3 was assigned when the response indicated a greater expression or elaboration of somatic symptoms, or when the overarching theme of the response reflected a focus on bodily irregularity (e.g., “*I have not been sleeping and eating properly*”). A code of 2 was assigned when the presentation of somatic and psychological symptoms was roughly equal, and 1 was assigned when there was greater emphasis on psychological symptoms, or when the overarching theme of the response reflected a focus on emotional irregularity (e.g., “*Lately, I have been feeling strong negative emotions that hinder my ability to go about my everyday life*”).

A similar coding strategy was used to evaluate the tendency to *minimize symptoms of distress*. A code of 3 was assigned when responses minimized symptoms of distress (e.g., vague presentation of symptoms; avoided talking about symptoms; denied any problems;

used minimizers such as “a little” and “slightly”), 2 when the response indicated a neutral presentation of symptoms, and 1 when the response indicated a tendency to emphasize the symptoms of distress (e.g., used words such as “extremely” and “all the time” or indicated a degree of helplessness).

Coding for the tendency to *suppress emotional expression* focused on presence (coded 1) or absence (coded 2) of emotional language (e.g., feeling “sad”, “depressed”, “low”, or “down”).

Two independent coders (the first author and a graduate clinical psychology student) coded the responses, with strong inter-rater reliabilities:  $r = .95$  for somatization,  $r = .85$  for minimization, and  $r = .98$  for suppression of emotional expression. Coding discrepancies were resolved through discussion until consensus was reached.

**Main Analyses.** Descriptive statistics for the sample by culture and results of statistical tests examining the cross-cultural variations in depression expression are provided in Table 1. Confirming H1, Chinese participants reported significantly more somatic symptoms and fewer psychological symptoms of depression ( $M = 2.07$ ,  $SD = 0.90$ ) than Australian participants ( $M = 1.48$ ,  $SD = 0.58$ ),  $t(53) = 2.88$ ,  $p = .006$ ,  $d = 0.78$ . There was also support for H2: Chinese participants minimized their symptoms of distress significantly more ( $M = 2.19$ ,  $SD = 0.71$ ) than Australians participants ( $M = 1.46$ ,  $SD = 0.58$ );  $t(62) = 4.42$ ,  $p < .001$ ,  $d = 1.13$ .

Chi-square analysis was used to examine the influence of culture on the suppression of emotion in the communication of depression symptoms (H3). As predicted, Chinese participants (55.6%) suppressed emotional expression significantly more than Australian participants (14.3%),  $\chi^2(1) = 11.45$ ,  $p = .001$ ,  $\Phi = 0.42$ .

Two separate hierarchical regression analyses were conducted to examine the influence of stigma (H4) and collectivism (H5) as moderators of the relationship between culture and somatization<sup>2</sup>. In the case of stigma (H4), both stigma and culture (Chinese versus Australian) were entered in Step 1. The interaction between culture and stigma was entered in Step 2 (Aiken & West, 1991). Results revealed that there was no significant effect of culture ( $\beta = -0.29$ ,  $t(51) = -1.87$ ,  $p = .067$ ) or stigma ( $\beta = 0.12$ ,  $t(51) = 0.76$ ,  $p = .450$ ) on somatic symptoms. Contrary to H4, the interaction between culture and stigma was not significant,  $\beta = -0.13$ ,  $t(51) = -0.90$ ,  $p = .374$ <sup>3</sup>.

Table 1  
*Results of Statistical Tests and Descriptive Statistics by Culture. Study 1; N = 66.*

Variable	Chinese Participants		Australian Participants		$t/\chi^2$	df	p
	M	SD	M	SD			
Tendency to somaticize	2.07	0.90	1.48	0.58	2.88	53	.006**
Tendency to minimize	2.19	0.71	1.46	0.58	4.42	62	<.001**
Tendency to suppress	1.56	0.50	1.14	0.36	11.45	1	.001**

\*  $p < .05$ , \*\*  $p < .01$

To examine whether collectivism moderated the relationship between culture and somatization (H5), collectivism and culture (Chinese versus Australian) were entered in Step 1, and the interaction term in Step 2. The analysis revealed that culture ( $\beta = -0.27$ ,  $t(51) = -2.14$ ,  $p = .038$ ,  $sr^2 = 0.063$ ) and collectivism ( $\beta = 0.31$ ,  $t(51) = 2.33$ ,  $p = .024$ ,  $sr^2 = 0.074$ ) each significantly predicted somatic symptoms, and consistent with H5, the interaction term was significant ( $\beta = -0.40$ ,  $t(51) = -3.24$ ,  $p = .002$ ,  $sr^2 = 0.143$ ). Simple slopes analysis revealed that collectivism was associated with higher reporting of somatic symptoms for Chinese participants,  $\beta = 0.74$ ,  $t(51) = 3.41$ ,  $p = .001$ , but not for Australian participants,  $\beta = -0.12$ ,  $t(51) = -0.78$ ,  $p = .437$  (see Figure 1).

## Discussion

In Study 1, confirming our predictions, we found that, relative to Australians, Chinese participants emphasized somatic symptoms (H1), minimized symptoms of distress (H2), and suppressed emotional expression (H3), when communicating depression in a health context. These findings provide support for cultural variability in the expression of depression symptoms.

In addition, we found that collectivism (H5) moderated the effect of culture on levels of somatic symptom reporting. Specifically, Chinese, but not Australian, participants were found to somaticize more when they endorsed collectivist values. That is, even though relative to Westerners, Chinese participants were more likely to emphasize somatic symptoms in the communication of depression symptoms (see also Ryder et al., 2008; Waza,



Graham, Zyzanski, & Inoue, 1999), to fully understand *when* Chinese participants somatized, it was important to examine the extent to which Chinese participants endorsed cultural values of collectivism. Importantly, although we found support for the moderating role of the endorsement of collectivism, this concept was arguably still measured as an individual difference and not so much as a cultural norm. Therefore, in our follow-up, we asked participants more specifically about the extent they felt that collectivism described Asian culture.

However, we found no support for our prediction that mental illness stigma would be a moderator of the effect of culture on somatization (H4). Although Chinese reported higher perceived stigma compared to Australians, stigma did not moderate the relationship between culture and somatization. Although this finding departs from the association between stigma and somatic symptoms proposed by a number of researchers (Chan & Parker, 2004; Goldberg & Bridges, 1988), it is consistent with the only other study examining this relationship (Ryder et al., 2008)<sup>4</sup>.

Having demonstrated that normative expectations influence depression expression, it is nevertheless true that not all people will be equal in the degree to which they see cultural norms as self-relevant. In Studies 2a and 2b, we test the prediction that norm conformity will only occur among individuals who *identify* strongly with their culture.

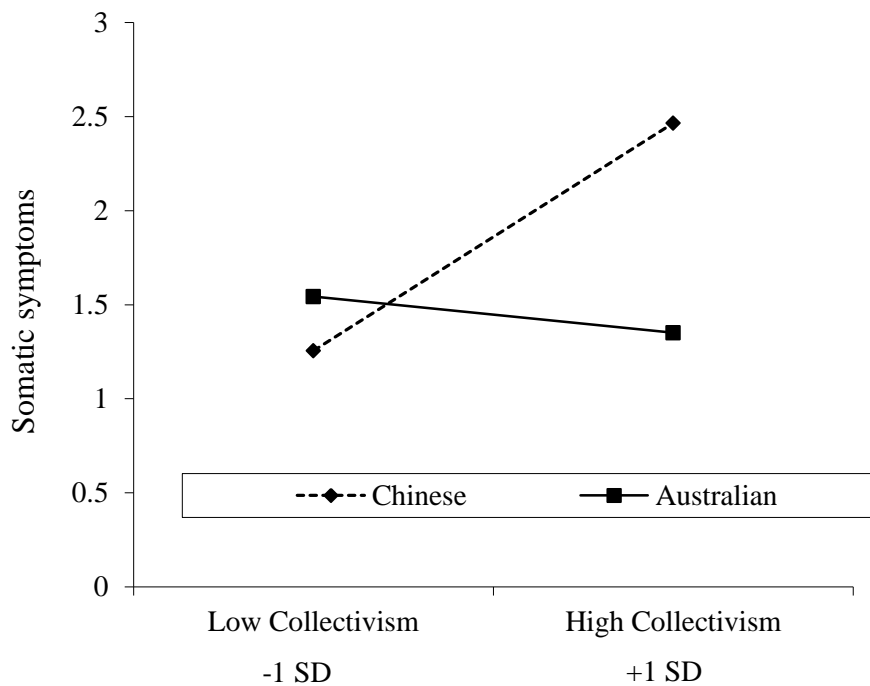


Figure 1. Level of somatic symptom reporting as a function of culture and normative expectations of collectivism. Study 1;  $N = 66$

## Study 2

Study 2 investigated whether, as the SIA predicts, the effect of normative expectations on somatic symptom expression is dependent on the strength of identification with one's culture. We examined this in two studies involving Asian international students in Australia (Study 2a) and Asian students in Singapore (Study 2b). Our prediction was that identification with Asian culture would moderate the effect of normative expectations on somatization. Specifically, we expected that normative expectations of perceived stigma (H6) and collectivism (H7) would influence somatization only among high identifiers with Asian culture.

### Study 2a

In Study 2a, we examined whether among a heterogeneous sample of participants from Asia, identification with Asian culture would moderate the effect of normative expectations of perceived stigma and collectivism on somatization.

### Method

**Participants.** Participants were 120 international students at a large Australian university who were born and raised in Asia (33 males, 87 females). Participants were recruited from a psychology research pool and either received course credit or \$10 for their participation. Participants had a mean age of 21.5 years ( $SD = 2.76$ ) and described their ethnicity as Asian, which in this study included Chinese, Taiwanese, and Vietnamese people.

### Procedures and Measures

Participants completed a survey that included demographic questions and the perceived stigma scale ( $\alpha = .68$ ) from Study 1. To measure the perception of collectivism as a cultural norm, participants indicated the extent to which the seven items of the Asian American Values Scale – Multidimensional (AAVS-M; Kim et al., 2005;  $\alpha = .73$ ), used in Study 1, described Asian cultures.

In addition, the following new measures of social identification and somatic symptom presentation were included.

**Social Identification.** Participants' strength of identification with Asian culture was measured with four items adapted from Doosje, Ellemers, and Spears (1995; e.g., "I identify with Asian culture";  $\alpha = .89$ ), to which participants responded using a 7-point scale (1=*Strongly disagree*, 7=*Strongly agree*).

**Somatic Depression Symptoms.** Somatic depression symptoms were assessed with seven items (e.g., "I did not feel like eating; my appetite was poor") from the Center for

Epidemiologic Studies Depression Scale somatic symptom subscale (CES-D; Radloff, 1977;  $\alpha = .62$ ). Each item was rated on a 4-point scale (0=*Rarely or none of the time*, to 3=*Most or all of the time*).

## Results and Discussion

Table 2 provides descriptive statistics and results of bivariate correlations between key variables. To test predictions, two regression analyses were conducted<sup>5</sup>. In the first analysis (H6), identification and stigma were added in Step 1, followed by the interaction term in Step 2. In this case, stigma significantly predicted somatic symptoms ( $\beta = 0.21$ ,  $t(111) = 2.26$ ,  $p = .026$ ), but contrary to H6, neither identification ( $\beta = -0.04$ ,  $t(111) = -0.44$ ,  $p = .661$ ) nor its interaction with stigma ( $\beta = -0.04$ ,  $t(111) = -0.43$ ,  $p = .668$ ) were significant.

Table 2  
*Descriptive Statistics and Correlations. Study 2a; N = 120.*

Variable	<i>M</i>	<i>SD</i>	1	2	3	4
1. Social Identification	6.05	0.87	--	.07	.04	-.04
2. Perceived stigma	4.46	1.08		--	-.08	.21*
3. Collectivism	4.41	0.78			--	.09
4. Somatic symptoms	0.98	0.47				--

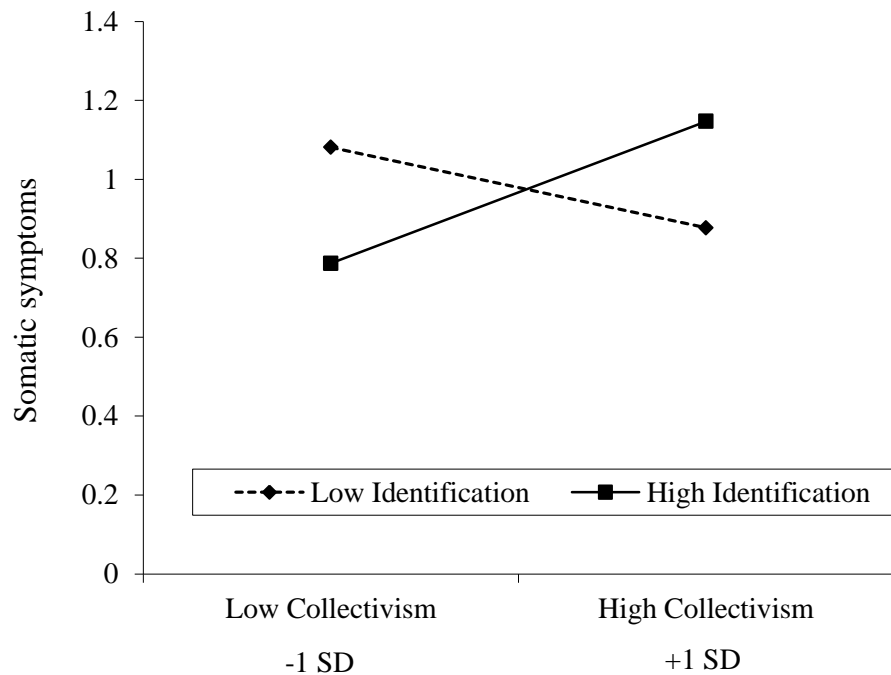
\*  $p < .05$ , \*\*  $p < .01$

A second regression analysis examined the relationship between collectivism and somatization. There was no significant effect of identification ( $\beta = -0.01$ ,  $t(116) = -0.14$ ,  $p = .889$ ) or collectivism ( $\beta = 0.08$ ,  $t(116) = 0.92$ ,  $p = .362$ ) on somatic symptoms. Consistent with our prediction (H7) though, the interaction term was significant,  $\beta = 0.24$ ,  $t(116) = 2.65$ ,  $p = .009$ ,  $sr^2 = 0.057$ . Simple slopes analysis revealed that collectivism predicted higher somatic symptoms for participants who identified more strongly with Asian culture,  $\beta = 0.38$ ,  $t(116) = 2.72$ ,  $p = .008$ , but was unrelated to somatic symptoms among those lower in identification,  $\beta = 0.22$ ,  $t(116) = -1.46$ ,  $p = .147$  (see Figure 2).

Results of Study 2a show that identification with Asian culture moderated the relationship between collectivism and somatization. Collectivism norms were associated with greater somatization only when Asian participants identified more strongly with Asian

culture. Interestingly, although we did not find evidence for a moderating role of stigma, stigma was associated with greater somatization.

Despite the fact that we found good support for our predictions, there are some limits to the study. Specifically, our hypotheses were examined in a sample of international students residing outside of their usual cultural contexts, which may have influenced their strength of identification with the Asian culture. We address this limitation in Study 2b.



*Figure 2.* Level of somatic symptom reporting as a function of social identification with Asian culture and normative expectations of collectivism. Study 2a;  $N = 120$ .

### Study 2b

Study 2b provided a replication of Study 2a in a sample of Asian students living within an Asian cultural context<sup>6</sup>.

### Method

**Participants.** Participants were 105 students at a large Singapore university (43 males, 62 females), who were recruited by distributing flyers at the university. Participants received 6 Singapore dollars for their participation. On average, participants were 21.4 years old ( $SD = 1.54$ ) and all described their ethnicity as Chinese.

### Procedures and Measures

Participants completed a survey that included demographic questions and scales from Study 2a measuring perceived stigma ( $\alpha = .69$ ), collectivism (AAVS-M; Kim et al., 2005;

$\alpha = .87$ ), social identification (Doosje et al., 1995;  $\alpha = .93$ ), and somatic depression symptoms (CES-D; Radloff, 1977;  $\alpha = .60$ ). In assessing these constructs however, any reference to Asian culture was replaced with Chinese culture (e.g., I identify with Chinese culture).

### Results and Discussion

Descriptive statistics and results of bivariate correlations between key variables are provided in Table 3. As in Study 2a, two regression analyses were conducted to test predictions. The first regression analysis examined whether identification would moderate the relationship between stigma and somatization (H6). Results showed that identification significantly predicted somatic symptoms ( $\beta = 0.20$ ,  $t(101) = 1.98$ ,  $p = .050$ ,  $sr^2 = 0.037$ ), but neither stigma ( $\beta = -0.03$ ,  $t(101) = -0.34$ ,  $p = .733$ ) nor its interaction with identification ( $\beta = 0.02$ ,  $t(101) = 0.16$ ,  $p = .877$ ) were significant.

Table 3  
*Descriptive Statistics and Correlations. Study 2b; N = 105.*

Variable	<i>M</i>	<i>SD</i>	1	2	3	4
1. Social Identification	5.52	1.01	--	.08	.32**	.20*
2. Perceived stigma	4.78	0.99		--	.06	-.02
3. Collectivism	4.84	0.98			--	.28**
4. Somatic symptoms	0.96	0.44				--

\*  $p < .05$ , \*\*  $p < .01$

A second regression analysis examined the relationship between collectivism and somatization. The analysis revealed that collectivism ( $\beta = 0.22$ ,  $t(101) = 2.25$ ,  $p = .027$ ,  $sr^2 = 0.043$ ) but not identification ( $\beta = 0.11$ ,  $t(101) = 1.15$ ,  $p = .252$ ) significantly predicted somatic symptoms, and consistent with H7, the interaction term was significant ( $\beta = 0.21$ ,  $t(101) = 2.22$ ,  $p = .029$ ,  $sr^2 = 0.042$ )<sup>7</sup>. Simple slopes analysis revealed that collectivism predicted higher somatic symptoms for participants who identified more strongly with

Chinese culture,  $\beta = 0.42$ ,  $t(101) = 3.27$ ,  $p = .001$ , but was unrelated to somatic symptoms among those lower in identification,  $\beta = 0.02$ ,  $t(101) = 0.13$ ,  $p = .898$  (see Figure 3).

In sum, we replicate the findings of Study 2a that identification moderated the relationship between collectivism and somatization. As in Study 2a, we also found that identification did not moderate the relationship between stigma and somatization. In this study, stigma was not associated with somatization.

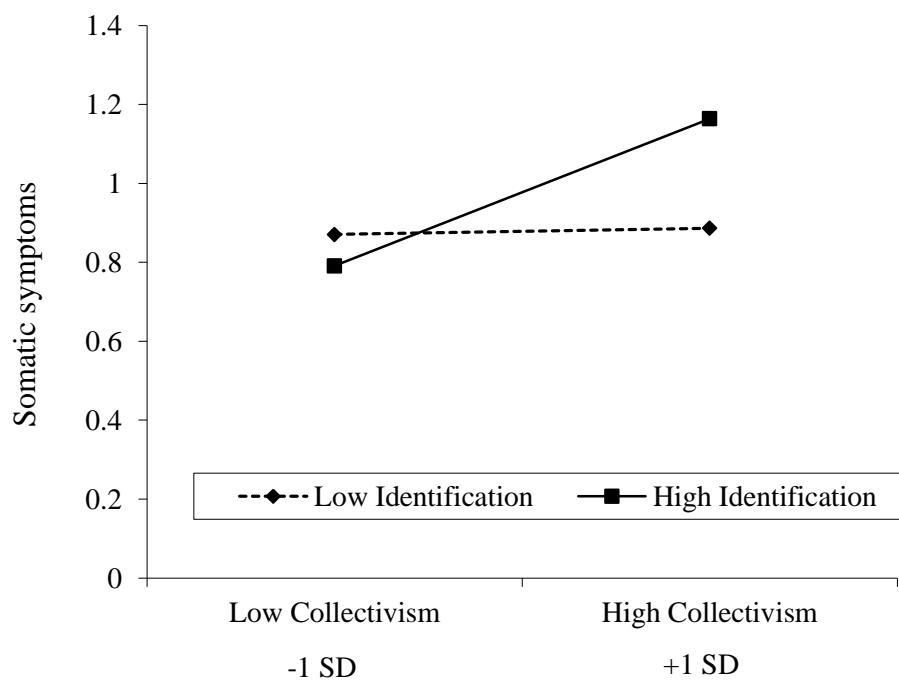


Figure 3. Level of somatic symptom reporting as a function of social identification with Chinese culture and normative expectations of collectivism. Study 2b;  $N = 105$ .

### General Discussion

The present studies draw on social identity theorizing to explore the cultural underpinnings of somatization, with the goal of understanding *when* culture affects depression expression. Consistent with previous research (Ryder et al., 2008; Waza et al., 1999), Study 1 showed that Chinese emphasized somatic symptoms relative to Westerners in the communication of depression symptoms. We also found evidence of greater somatization to the extent that Chinese participants endorsed the normative expectations of collectivism.

Consistent with our prediction, across two different samples of Asian participants, Studies 2a and 2b found that collectivism norms were associated with higher levels of reported somatic depression symptoms, but only among people who strongly identified with Asian culture. In line with social identity theorizing, this finding highlights that identification

processes are central to somatic expression of depression. It is only in the context of cultural identification (i.e., cultural identity is internalized as an important and meaningful aspect of self) that normative expectations will be adopted and influence behavior.

These findings have important implications for the conceptualization of culture and its influence on psychological processes. They highlight that culture does not influence individuals' behaviors in a fixed and deterministic way. For many years, much research in psychology has sought to understand the influence of culture in terms of a rigid value held by its member; akin with treating culture as an "in-the-head" trait (Markus & Kitayama, 1991; Triandis, 1989). This assumes that all exposed to the same cultural environment would endorse and be influenced by that culture to the same extent (Hong & Chiu, 2001; Wan & Chiu, 2009). However, in recent years, cultural psychologists have started to appreciate the dynamic nature of cultural influence (Hong, Morris, Chiu, & Benet-Martinez, 2000; Ng, Han, Mao, & Lai, 2010). Our findings therefore add to this growing literature by illustrating that there are clearly conditions in which culture influences depression expression.

Consistent with the SIA, we demonstrated that factors such as norm endorsement and social identification differentially affect the expression of depression symptoms as a function of culture. Mere knowledge of a person's cultural heritage, as Eastern or Western, is therefore not predictive of somatization. Instead, individuals are active agents in how they live out their culture (Herman, 2001). As shown here, it is only when cultural identity is internalized as an important and meaningful aspect of self, with endorsement of cultural expectations, that it has the power to shape behaviors — even to the extent of influencing the manifestation of depression. This also reminds us of the variability *within cultures* in depression expression, which is often overlooked in cross-cultural studies, thereby possibly resulting in cultural stereotyping (Hong & Chiu, 2001; Tsai, Chentsova-Dutton, & Wong, 2002).

We found no support for our prediction that strength of cultural identity moderated the relationship between perceived stigma and somatization<sup>8</sup>. This unexpected finding suggests that perceived stigma may not be the process through which cultural differences in depression somatization present in Chinese people. Of course, this does not rule out the influence of other more specific types of stigma (e.g., perceptions of family shame). Specifically, in light of the belief in Chinese culture that mental illness is a sign of weakness that brings disgrace to the family (Lam et al., 2010; Yang, 2007) and the collectivistic nature of Chinese societies, shame to the family might be more central than generalized stigma to

understand the phenomenon of Chinese somatization. This prediction was not the focus of the present investigation but should be examined in future research.

It is worth noting that social identification was not significantly related to somatic symptoms in Study 2a and it was significantly associated with higher levels of somatic symptoms in Study 2b. This suggests that social identification may not be associated with lower levels of depression. Intriguingly, at first sight, this finding seems to depart from literature highlighting the central role that social identification plays in protecting mental health and wellbeing (Cruwys, Haslam, Dingle, Haslam, & Jetten, 2015; Sani, Herrera, Wakefield, Boroch, & Gulyas, 2012). More specifically, this work has found that a sense of shared identity can act as a psychological resource, allowing individuals to draw upon effective social support in times of need (Jetten, Haslam, Haslam, Dingle, & Jones, 2014). Of note, however, is that much of this work on social identification and wellbeing has been conducted primarily in Western societies. In one of the few studies conducted using Asian samples, it was found that Asians derived fewer support resources and wellbeing benefits from identification with multiple groups relative to Westerners. This is because Asian cultural norms about relationships and support seeking (i.e., concerns about burdening others; Chang, Jetten, Cruwys, Haslam, & Praherso, 2016) can potentially make Asians more reluctant to enlist social support from their group memberships, which may help explain the inconsistent finding. As such, rather than simply assuming a positive relationship between social identification and wellbeing, it may be important to consider the content of the identity (i.e., normative expectations tied to the identity). Consistent with this, research has suggested that social identification is not protective of wellbeing when the content of the identity is negative or stigmatized (Crabtree, Haslam, Postmes, & Haslam, 2010; Cruwys & Gunaseelan, 2016).

### **Limitations and Future Research**

We note that the current studies are not without limitations. Besides the modest sample size in Study 1, a limitation of all the studies is that the cross-sectional nature of the data does not permit us to make causal inferences, and thus, directionality of effects cannot be established. Furthermore, because the samples comprised only college students, our findings may not generalize to a non-college population or to clinical populations. All these limitations should be addressed in future work by examining the generalizability of findings to other populations and by examining evidence for the predicted relationship longitudinally. Furthermore, as collectivism is a broad cultural construct, more specific beliefs about emotion subsumed under collectivism could be examined in future work. Nevertheless, the



current work investigating collectivism as a cultural norm is important because many studies have shown that collectivism often accounts for the largest amount of variance in explaining cross-cultural differences when a sufficiently large set of nations is used (Georgas, Van de Vijver, & Berry, 2004; Hofstede, 2001).

### **Implications**

This study has important implications for practitioners working with Asians. Our current understanding of depression presented in the DSM-5 and the Western literature emphasize the psychological features of the condition. In doing so, they may be less sensitive and accurate in diagnosing individuals from different cultural backgrounds. This is consequential because it may lead to under-detection and misdiagnosis of depression, and inadequate treatment (Comino et al., 2001; Hwang et al., 2008).

When working with Asian clients with depression, it is important to be mindful of how Asians conceptualize the condition (i.e., emphasizing somatic symptoms), and normalize and validate their experience of the condition (Zhang, 1995). For instance, practitioners could utilize words commonly used by depressed Asian individuals to describe their depression (e.g., somatic symptoms such as not sleeping well), instead of labeling it generically as depression. In addition to improving diagnostic accuracy, this will facilitate the building of rapport and subsequently therapeutic change.

There is a growing interest in cultural competence and culturally sensitive clinical practice; a core priority of most clinical training programs (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Sue, Zane, Hall, & Berger, 2009). Our findings add to this movement by identifying *when* Asians are more likely to somaticize relative to Westerners, and reminding professionals of the variability not just between but also *within* cultures. Indeed, Sue (1998) argued that effective clinicians should avoid stereotyping members of a cultural group while still appreciating the importance of cultural influence. This facet of cultural competence, termed dynamic sizing, captures the ability to work appropriately within the client's context, whether that client has characteristics typical of, or idiosyncratic to, the client's cultural group.

### **Conclusion**

Research has perhaps focused too strongly on the question of *whether* Chinese people somaticize. To move this field forward, we propose drawing on social identity theorizing to help understand *when* culture affects depression expression. Our findings indicate that mere knowledge of a person's culture is not predictive of whether individuals somaticize. Rather, identification with culture, and norm endorsement, is key. In demonstrating this, our findings

highlight the powerful and dynamic nature of culture in shaping the expression of psychopathology.

## Footnotes

<sup>1</sup> A cultural norm of stigma was also measured in the Australian/Western context, and the results were the same as those measured in the Asian context.

<sup>2</sup> The study also explored mediation and moderation effects of emotional self-control, which was measured with the AAVS-M (Kim et al., 2005). However, this analysis revealed no significant relationships.

<sup>3</sup> Results suggest that some of the variability in somatization explained by culture is explained by the interaction between culture and stigma.

<sup>4</sup> In our study, stigma was conceptualized as a cultural norm. This differs from the only prior empirical study investigating stigma and depression somatization in Chinese people (Ryder et al., 2008), in which stigma was measured as individual differences, and it was not found to mediate or moderate the relationship between culture and somatization.

<sup>5</sup> A factor analysis of the Center for Epidemiologic Studies Depression Scale (CES-D) somatic symptom items was conducted in Studies 2a and 2b. All except one item, “I felt that everything I did was an effort”, loaded onto a single factor. Moderation analyses reported in Studies 2a and 2b were additionally conducted excluding this item and these yielded similar results with the key conclusions replicated. For this reason, we reported analyses using the full somatic symptom subscale of the CES-D.

<sup>6</sup> These data were part of a larger study that included measures of multiple group membership, life satisfaction, and reluctance to enlist social support.

<sup>7</sup> To ensure that age and gender did not account for any of the effects, these were entered as control variables in all the regression analyses reported above (i.e., Studies 1 and 2). Adding these covariates produced comparable results yielding the same conclusions.

<sup>8</sup> Given that normative expectations of stigma were associated with greater somatization in Study 2a, an alternative interpretation could be that this relationship may hold true for people in general, and as such, may not be a cultural phenomenon. This could possibly help explain why we did not find that identification moderated the effect of stigma on somatization. However, this alternative explanation may be ruled out by findings of Study 1 and Study 2b, where no such association between stigma and somatization was found among Asian and Australian participants. Taken together, the mixed findings limit our ability to derive a conclusive understanding of the role of stigma on somatization among Asians.

### **Chapter 3: To Value or not to Value Happiness: Culture Shapes Whether Placing Social Value on Happiness Backfires**

#### **Abstract**

In Western cultures, considerable emphasis is placed on happiness. Previous work has shown that these salient cultural norms communicating the pursuit of happiness and avoidance of unhappiness are, rather paradoxically, associated with higher levels of depression in Westerners. By contrast, in East-Asian cultures, these goals are not normative. We therefore predict that the costs associated with social norms to feel happy are specific to Westerners, and should not affect the reporting of depression symptoms among East-Asians. The present study tested this prediction. Consistent with this analysis, we found that Westerners ( $N = 176$ ) were stronger advocates of the happiness norms than East-Asians ( $N = 205$ ). Results also showed that the degree to which this norm was endorsed was associated with higher levels of depression symptoms among Westerners, but lower levels of depression symptoms among East-Asians. Negative self-evaluations in response to unhappiness were found to mediate this relationship for Westerners only. The evidence underscores the importance of culture in shaping whether placing social value on happiness backfires.

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## **To Value or not to Value Happiness: Culture Shapes Whether Placing Social Value on Happiness Backfires**

Today, happiness is often promoted as a valuable goal; one that is important for wellbeing and a meaningful life (Seligman & Csikszentmihalyi, 2000). These messages about the value of happiness are constantly reinforced in our social and cultural contexts, especially in Western societies (e.g., with national campaigns focusing on increasing happiness, thousands of self-help books touting the secrets to unlimited happiness). The salience of these cultural norms clearly communicates that we should strive to be happy and not to feel sad (Bastian et al., 2012). At first glance, one might assume that this collective emphasis on happiness should lead to positive outcomes.

Surprisingly, however, a growing body of work finds evidence of a paradoxical effect: that placing social value on happiness can at times impair personal wellbeing (Bastian, Kuppens, De-Roover, & Diener, 2014; Bastian et al., 2012; Harris, 2007). Specifically, endorsement of these norms for happiness has been found to reduce people's satisfaction with life, increase their levels of depression, and enhance the experience of social isolation in the context of experiencing sadness (Bastian et al., 2012, 2015). This is because happiness norms may be a source of social pressure on people to feel happy (and not to feel unhappy), thereby promoting negative self-evaluations when unhappiness is experienced which, in turn, amplifies these unwanted emotions and reduces wellbeing (see Bastian, 2013, for a review, see also Bastian et al., 2012; Carver & Scheier, 1982; Moberly & Watkins, 2008). Importantly, this research has found that these happiness norms predict emotional dysfunction more consistently than, and independently of, personal expectations about emotional experiences (Bastian et al., 2012). We extend this research to test the hypothesis that the negative consequences of these happiness norms may be specific to Western contexts.

### **Happiness Norms and Wellbeing: A Cross-cultural Perspective**

There is some indirect evidence to support our contention that the downside of social norms for happiness may be specific to Westerners. Recent cross-cultural studies have shown that cultures vary in their beliefs and theories regarding positive and negative emotions (Bastian et al., 2012; Eid & Diener, 2001). In Western cultures, feeling happy is considered a fundamental value, and the dominant cultural script is to value and encourage happiness, and to avoid negative emotions (Kitayama, Markus, & Kurokawa, 2000; Ryan & Deci, 2001). In these contexts, the norm to strive for happiness is therefore especially salient, possibly generating heightened social pressures to feel happy, which in turn may instigate people to reflect negatively on the self when experiencing unhappiness (Bastian et al., 2012).

By contrast, in East-Asian contexts, the goal to strive for happiness and avoid unhappiness is less normative. It has been proposed that in East-Asian cultures, the dominant cultural script is grounded in dialectical thinking, where reality is considered to be constantly changing and comprised of opposites and contradictions (Peng & Nisbett, 1999), as manifested in a Chinese quote by Lao Tze “happiness rests in misery, misery hides in happiness” (Tao Te Ching, Chapter 58). In these cultures, happiness and unhappiness are seen to coexist and complement each other (Miyamoto & Ma, 2011; Spencer-Rodgers, Peng, & Wang, 2010). Along these lines, compared to Westerners, East-Asians are more likely to perceive that there are negative aspects of happiness (e.g., carrying negative social consequences such as envy; Joshanloo & Weijers, 2014; Miyamoto & Ma, 2011; Uchida & Kitayama, 2009). Moreover, East-Asians are more likely than Westerners to accept negative emotions as part of normal reality, and perceive some desirable aspects of unhappiness (e.g., as a source of motivation to improve the self; Uchida & Kitayama, 2009; Miyamoto, Ma, & Petermann, 2014).

Overall then, the singular focus on the desirability of happiness is not as apparent within East-Asian, relative to Western, cultures. This raises the possibility that East-Asians may be less affected by the social pressures associated with social norms to feel happy (and not to feel unhappy), and thus, less inclined to reflect negatively on the self and experience reduced wellbeing when experiencing unhappiness. On these grounds, we argue that the paradoxical effect of happiness norms may be unique to Western cultures (see Figure 1).

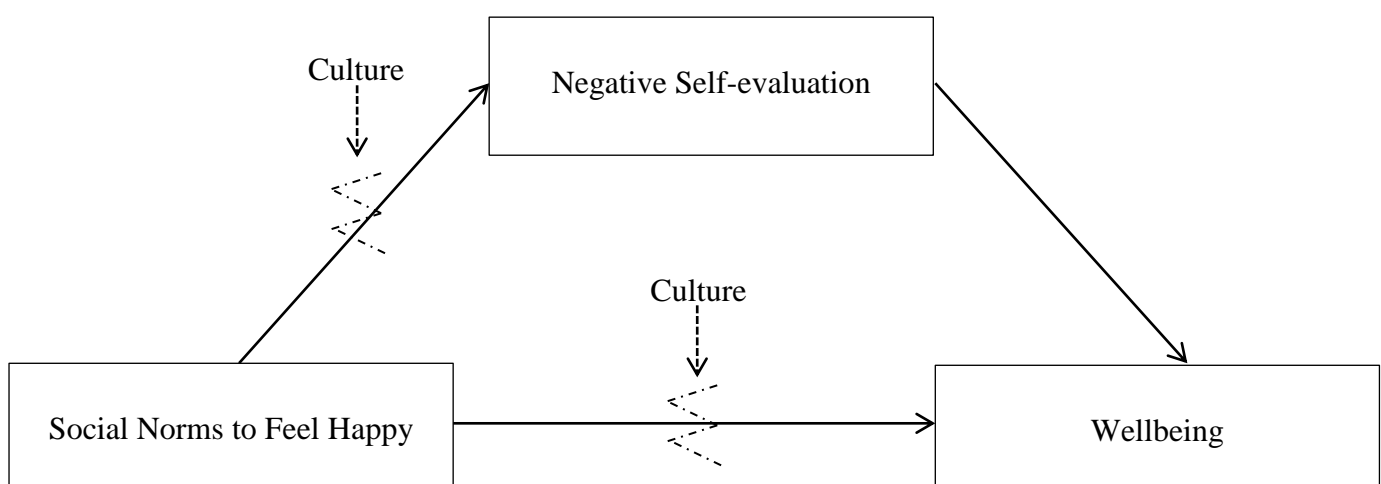
The existing literature, however, has several limitations. First, the work on social norms for emotional experience has focused almost exclusively on norms *not to feel unhappy* (rather than to feel happy), despite theoretical arguments centring largely on the detrimental effects that societies place on pursuing happiness (Bastian, 2013; Bastian et al., 2012). In fact, the basis for the ironic effects of happiness norms is substantiated by research documenting the costs of highly valuing happiness — reduced wellbeing, higher depressive symptoms, and compromised social outcomes (Ford, Shallcross, Mauss, Floerke, & Gruber, 2014; Mauss et al., 2012; Mauss, Tamir, Anderson, & Savino, 2011).

Second, this body of research has focused on the *individual's* pursuit of the emotional goal towards happiness (i.e., wanting and valuing happiness at a personal level). There is only one study that has investigated happiness norms (i.e., perceptions of how others within the social environment value and approve happiness; Bastian, 2014). Furthermore, this evidence is mixed, with the only study directly examining the influence of happiness norms showing

that placing social value on *positive* emotions enhances life satisfaction (Bastian et al., 2014). However, a limitation of this study is that the social valuation measure relied on just one item.

Third, despite research showing cultural differences in beliefs about experiencing positive emotions and avoiding negative emotions, the work on emotion norms has primarily been conducted within Western contexts; where a high premium is placed on happiness. The findings from the only study that has examined cross-cultural differences in the effects of happiness norms were inconclusive. Bastian et al. (2012) found that while the effects of happiness norms on wellbeing were less pronounced in Japan than in Australia (a higher premium is placed on happiness in the latter than in the former country), their reduced wellbeing consequences were evident in both cultures. This is inconsistent with Bastian et al. (2014) who found that happiness norms were associated with increased life satisfaction (though not in a cross-cultural study), and with Ford et al. (2015), who found that individual-level (as opposed to collective-level) motivations to pursue happiness predicted lower wellbeing in the United States, but higher wellbeing in East-Asia.

From these studies, it is difficult to draw firm conclusions about the influence of happiness norms at the collective-level. Their scope, particularly those focusing on individual-level values, is limited, and the findings are mixed. Furthermore, it remains unclear how these norms influence wellbeing in East-Asian and Western contexts. We therefore question the generalizability of the effects of happiness norms and address whether culture moderates the effects of these norms on wellbeing.



*Figure 1.* Proposed relationship between social norms to feel happy and personal wellbeing, with breaks indicated where we hypothesize the relationship to be influenced by culture.

## The Present Study

The present research investigated, in East-Asian and Western cultural contexts, whether there are cultural differences in the relationship between social norms for happiness and personal wellbeing. In this study, we adopted depression as an indicator of wellbeing. We predicted that happiness norms would be higher in Western than in East-Asian cultures (H1), and that perceiving these norms would be associated with higher levels of depression symptoms in Westerners, but lower levels of such symptoms for East-Asians (H2). Finally, given that norms to strive for happiness are especially salient in Western cultures, we predicted that negative self-reflections in response to unhappiness would only mediate the effect of happiness norms on depression in Westerners, but not for East-Asians (H3).

## Method

### Participants

**East-Asian Participants.** Participants were 205 undergraduate students aged 17-23 from a large university in China (96 males, 109 females). Participants were recruited by randomly selecting from three undergraduate lectures and participation was voluntary. East-Asian participants were on average 20.1 years old ( $SD = 1.05$ ) and all described their ethnicity as Chinese.

**Western Participants.** Participants were 176 undergraduate students aged 18-25 recruited from a psychology research pool at a large Australian university (53 males, 123 females). Participants received course credit for their participation. On average, participants were 18.9 years old ( $SD = 1.35$ ) and all described their ethnicity as Caucasian.

### Measures

Participants in both countries were provided with the same questionnaire, with back translation procedures used in the Chinese version.

**Perceived Social Norms to Feel Happy.** Social norms to feel happy were assessed with six items (see Bastian et al., 2012; East-Asian,  $\alpha = .81$ ; Western,  $\alpha = .80$ ). Examples of items include: “Other people expect me to feel happy” and “People like me more when I feel happy”. Each item was rated on a 9-point scale (1=*Strongly disagree*, 9=*Strongly agree*)<sup>1</sup>.

**Negative Self-evaluation when Unhappy.** Participants were asked to indicate the extent to which they evaluated themselves negatively when experiencing unhappiness (see Bastian et al., 2012). This was assessed with two items (i.e., “Feeling unhappy makes me dislike myself”, “When I feel unhappy, I feel like a bad person”; East-Asian,  $r = .51$ ; Western,  $r = .75$ ). Each item was rated on a 9-point scale (1=*Strongly disagree*, 9=*Strongly agree*).



### The Center for Epidemiologic Studies Depression Scale – Shortened Version.

(CESD-10; Andresen, Malmgren, Carter, & Patrick, 1994). Ten items (e.g., “I was bothered by things that usually don’t bother me”) assessed depression symptoms (East-Asian,  $\alpha = .79$ ; Western,  $\alpha = .84$ ). Participants were asked to indicate how much the items had applied to them during the past week on a scale ranging from 0=*Rarely or none of the time*, to 3=*Most or all of the time*.

### Results

Descriptive statistics for the sample by culture are provided in Table 1. Consistent with H1, Western participants ( $M = 7.60$ ,  $SD = 1.01$ ) reported significantly greater endorsement of social norms to feel happy than East-Asian participants ( $M = 6.90$ ,  $SD = 1.37$ ),  $t(370) = -5.68$ ,  $Z = 4.55$ ,  $p < .001$ ,  $d = 0.58$ .

Table 1

*Descriptive Statistics and Correlations as a Function of Culture. N = 381.*

Variable	Western Participants					East-Asian Participants				
	<i>M</i>	<i>SD</i>	1	2	3	<i>M</i>	<i>SD</i>	1	2	3
1. Social Norms to Feel Happy	7.60	1.01	--	0.18*	0.15*	6.90	1.37	--	-0.04	-0.31**
2. Negative Self-evaluation	4.98	2.27		--	0.28**	3.88	2.10		--	0.36**
3. Wellbeing: Depression	0.99	0.57			--	0.94	0.52			--

\*  $p < .05$ , \*\*  $p < .01$

A moderation analysis (Hayes, 2013, model 1) was conducted to examine the influence of culture as a moderator of the relationship between happiness norms and depression (H2). Results showed that neither culture,  $\beta = 0.06$ , 95% CI [-0.04, .16],  $t = 1.11$ ,  $p = .268$ , nor happiness norms,  $\beta = -0.06$ , 95% CI [-0.16, .05],  $t = -1.03$ ,  $p = .305$ , significantly predicted depression in the full sample. However, consistent with H2, the interaction between culture and happiness norms was significant,  $\beta = 0.23$ , 95% CI [.12, .35],  $t = 4.12$ ,  $p < .001$ . Simple slopes analysis revealed that the more social norms prescribed happiness, the more depression symptoms were reported by Western participants,  $\beta = 0.20$ , 95% CI [.00, .39],  $t =$

1.97,  $p = .050$ , and the fewer depression symptoms were reported by East-Asian participants,  $\beta = -0.27$ , 95% CI [-.38, -.16],  $t = -4.89$ ,  $p < .001$  (see Figure 2).

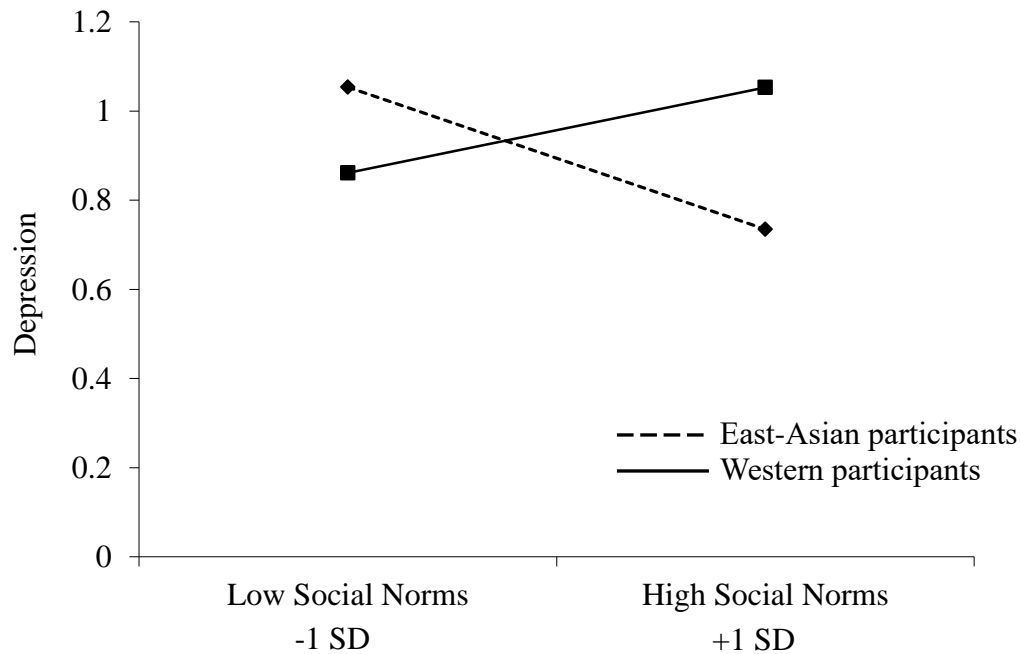


Figure 2. Levels of depression symptoms reporting as a function of social norms to feel happy and culture.  $N = 381$ .

To examine the role of negative self-evaluation when experiencing unhappiness, a mediation analysis with 10,000 bootstrap samples was conducted for each cultural sample (H3; Hayes, 2013, model 4). Consistent with H3, in the Western subsample, the indirect effect (IE) of happiness norms on depression was significant, such that increased norms for happiness were associated with higher levels of reported depression symptoms through higher negative self-evaluation in response to unhappiness,  $IE = 0.03$ , standard error[SE] = 0.01, 95% CI [.00, .06]. This represents a small effect,  $k^2 = 0.05$ , 95% CI [.01, .11] (Preacher & Kelley, 2001). The direct effect of happiness norms was not significant after incorporating this indirect effect ( $p = .171$ ; see Figure 3).

In the East-Asian subsample, the indirect effect of happiness norms on depression was not significant,  $IE = -0.01$ , standard error[SE] = 0.01, 95% CI [-.02, .01] (see Figure 3)<sup>2</sup>. We also tested the most plausible alternative mediation model, which was that depression predicted perceived social norms to feel happy, via increased negative self-evaluation. That is, it is possible that people who feel more depressed would encounter others who would be critical of them in this regard, and convey to them that they ought to feel happy and

experience less of these negative emotions. However, this model was not consistent with the data. In both the Western,  $IE = 0.07$ , standard error[SE] = 0.05, 95% CI [-.003, .20], and East-Asian,  $IE = 0.08$ , standard error[SE] = 0.08, 95% CI [-.06, .27], subsamples, the indirect effect of depression on happiness norms was not significant. As a further sensitivity analysis, we investigated whether levels of depression moderated the association between social norms to feel happy and negative self-evaluation. That is, it is possible that happiness norms and negative self-evaluation would be more closely related among those who experience high levels of depression (Bastian et al., 2012). Analysis revealed that the interaction between happiness norms and depression on negative self-evaluation was not significant for either Western,  $\beta = 0.02$ , 95% CI [-.16, .21],  $t = 0.26$ ,  $p = .795$ , or East-Asian,  $\beta = 0.09$ , 95% CI [-.05, .22],  $t = 1.29$ ,  $p = .199$ , participants.

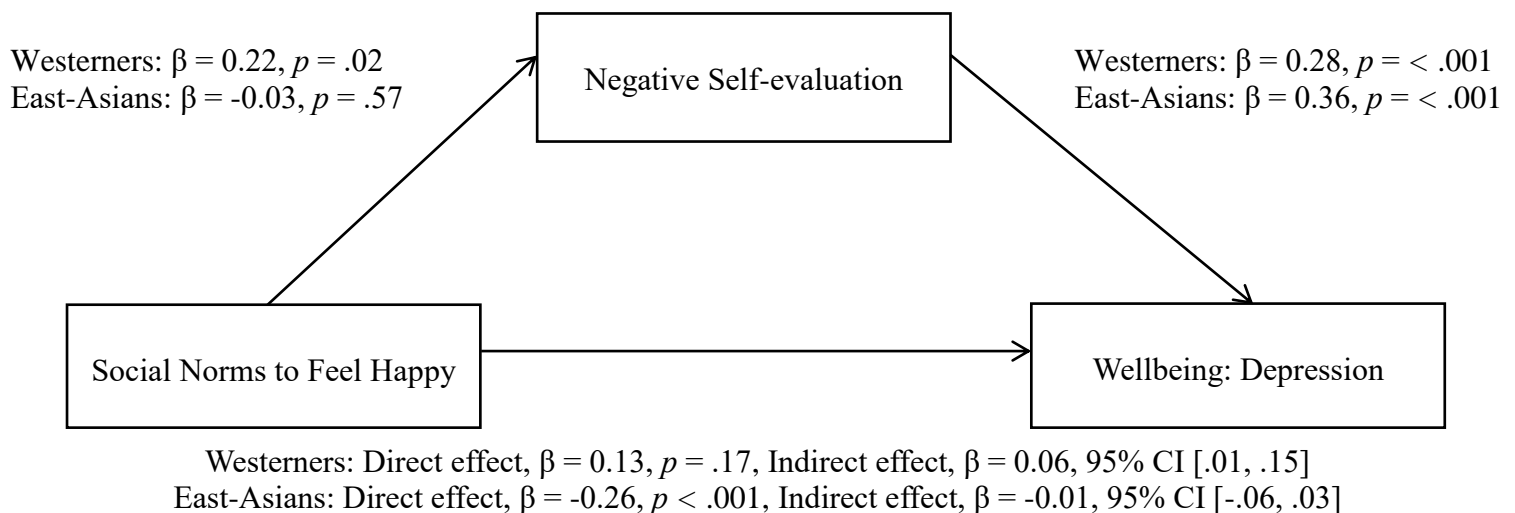


Figure 3. Negative self-evaluation mediates the effects of social norms for happiness on depression for Western, but not East-Asian, participants.  $N = 381$ .

### Discussion

In our study, we found support for our argument that the rather paradoxical negative association between happiness norms and wellbeing (Bastian et al., 2012, Ford et al., 2014) is not a universal phenomenon. Importantly, this provides some of the first evidence showing the boundary conditions of this effect, with the relationship being specific to Western contexts.

Specifically, we found that happiness norms were significantly higher in Western than in East-Asian cultures (H1). This suggests that culture shapes how normative it is to feel happy, with a higher premium placed on happiness at a societal level in Western contexts.

We also replicated the effect that happiness norms were associated with higher levels of depression symptoms for Westerners (Bastian et al., 2012). However, a novel finding here was that for East-Asians, happiness norms were associated with reporting of fewer depression symptoms, suggesting that placing social value on happiness may backfire for the wellbeing of Westerners, but not East-Asians (H2). Interestingly though, this finding departs from that of Bastian et al. (2012), who found that although social norms for happiness were more strongly associated with higher levels of depression in Western than in East-Asian cultures, this positive association was evident in both cultures. Of note, however, is that in the study by Bastian et al. (2012), social norms for happiness were measured in terms of social norms *not to feel unhappy*, while we measured these norms as social norms *to feel happy*. It is possible that this different framing may explain the inconsistencies. This is in fact in line with Tversky and Kahneman's argument (1981), that changes of perspective can often reverse the relative desirability of options. People may have different preferences depending on the framing of the problem (e.g., lives lost or saved). More importantly, supporting our finding, a cross-cultural study investigating a very similar construct (i.e., individual's pursuit of happiness) found that an individual's motivation to pursue happiness (focusing on individual-level values) was associated with lower wellbeing in the United States, but higher wellbeing in East-Asia (Ford et al., 2015).

The present analysis also sheds new light on how cultural backgrounds can affect the extent to which people reflect negatively on the self in response to negative emotions experienced in contexts where happiness norms are endorsed. Consistent with H3, we found that negative self-evaluation in response to unhappiness mediated the effect of happiness norms on depression for Westerners, but not East-Asians. The current work therefore provides the first empirical demonstration that compared to Westerners, East-Asians may reap more wellbeing benefits from happiness norms, possibly because of the emphasis on different cultural scripts about positive and negative emotions across cultures. Among Westerners, the greater emphasis placed on happiness (i.e., happiness as socially desirable and unhappiness as socially undesirable) may increase negative self-reflections when unhappiness is experienced, resulting in higher levels of depression. Conversely, the present analysis suggests that East-Asians appear to be less affected by the social pressures associated with happiness norms, and therefore are less inclined to reflect negatively on the self when experiencing unhappiness, which, in turn, is associated with lower levels of depression. These findings are in keeping with research showing positive emotions to be less

valued and negative emotions to be more valued in East-Asian, compared to Western, contexts (Joshanloo & Weijers, 2014; Miyamoto & Ma, 2011; Miyamoto et al., 2014).

Of course, the current study is not without limitations. First, the cross-sectional nature of the data does not permit us to make causal inferences about the directionality of effects. It is worth noting, though, that the alternative models tested did not provide a superior fit for the data. Also, because the samples comprised only college students, our findings may not generalize to a non-college population. Furthermore, although we found that happiness norms were more pronounced in Western than in East-Asian contexts, it remains unclear whether this biased emphasis on happiness in the West is the main driver of higher levels of depression symptoms reporting. This is in line with the argument though, that too much happiness may actually be harmful (Grant & Schwartz, 2011). An alternative explanation for the increased depression symptoms reporting in Western samples could be that unhappiness is less likely to be perceived as having utility in Western than in East-Asian cultures (Miyamoto et al., 2014). This may lead to more social pressures to feel happy as well as negative self-evaluations in response to unhappiness when in contexts that emphasize the value of happiness. Future research could examine these processes in greater detail.

Nevertheless, the current work provides important insights about the role of happiness norms in different cultural contexts; notably, that they function differently across cultures. More specifically, it highlights the circumstances in which happiness norms are associated with higher levels of depression. This has important practical implications for campaigns or wellbeing interventions which promote the value of happiness. Perhaps, communicating social norms regarding the value of happiness may have beneficial effects leading to enhanced wellbeing only when such norms do not result in people reflecting negatively on the self when experiencing unhappiness (e.g., acceptance of unhappiness; Hayes, Stroshal, & Wilson, 2003).

## **Conclusion**

The present research provides the first empirical evidence that the impact of happiness norms differ across cultures. The commonly reported paradoxical negative relationship between happiness norms and wellbeing may be unique to Western cultures. This is because in these contexts, where norms for happiness are especially salient, they give rise to negative self-evaluations when people experience unhappiness. By contrast, in East-Asian cultures, where these norms are less salient, they do not seem to promote negative self-reflections among people who do perceive these norms. In sum, culture shapes whether placing social value on happiness is likely to result in enhanced or — paradoxically — reduced wellbeing.

## Footnotes

<sup>1</sup> We performed oblique Procrustes rotation (which allows for factors to correlate) to evaluate the structural equivalence of perceived social norms to feel happy subscale and negative self-evaluation when unhappy subscale between East-Asian and Western subsamples (Fischer & Fontaine, 2010). Four congruence coefficients were computed to indicate the factorial agreement attained; the linearity, the proportionality (Tucker's phi), the additivity, and the identity coefficient, with a value of above .90 suggesting good factorial agreement (Fischer & Fontaine, 2010). Analysis revealed 2 factors (i.e., social norms, negative self-evaluation) for both East-Asian and Western participants. For both factors, the values of various agreement coefficients were all above .90 (.95 - .99). This suggests that the factor structure is similar for these 2 cultural samples.

<sup>2</sup> To ensure that age and gender did not account for any of the effects, these were entered as control variables in the moderation and mediation analyses reported above. Adding these covariates produced comparable results yielding the same conclusions.

## Chapter 4: Why negative emotions are not equally bad for wellbeing across cultures: The role of social norms<sup>4</sup>

### Abstract

A growing body of research has shown cultural variation in the wellbeing consequences of negative emotions, with negative emotions adversely influencing the wellbeing of European-Americans to a greater degree than is the case for East-Asians' wellbeing. However, what has rarely been explored are the explanatory mechanisms accounting for some of the observed cultural differences. We propose that cultural differences in social norms regarding unhappiness may underlie this commonly demonstrated effect. Specifically, we propose that in Western contexts, experiences of unhappiness take a greater toll on individuals' wellbeing because unhappiness is construed as more undesirable and problematic than in East-Asian contexts, where unhappiness is construed as (relatively) acceptable. Consistent with this, we found that Westerners ( $N = 176$ ) viewed unhappiness as more undesirable and unacceptable than East-Asians ( $N = 205$ ). Results also showed that social norms for unhappiness accounted for the moderating effect of culture on the unhappiness-wellbeing link. The evidence highlights the importance of cultural norms regarding acceptance of unhappiness. These norms were able to buffer the harmful effects of unhappiness on wellbeing among East-Asians, helping us to understand why negative emotions may be less impactful on the wellbeing of East-Asians relative to Westerners.

This chapter is from a manuscript under review.

Chang, M. X. L., Jetten, J., Cruwys, T., Haslam, C., Yang, J., & Xiong, X. (2017). Why negative emotions are not equally bad for wellbeing across cultures: The role of social norms. *Manuscript under review*.

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<sup>4</sup> In this chapter, we examined two wellbeing indicators, depression and life satisfaction.

## **Why negative emotions are not equally bad for wellbeing across cultures:**

### **The role of social norms**

Negative emotions, like unhappiness, are often viewed as universally and unequivocally bad for people's physical and psychological health (Consedine & Moskowitz, 2007; Pressman, Lopez, & Gallagher, 2013; Suh, Diener, Oishi, & Triandis, 1998). Yet, a growing body of research has revealed that the strength of this relationship depends on culture (e.g., Consedine, Magi, Cohen, & Gillespie, 2002; Consedine et al., 2006; Curhan et al., 2014; Kitayama et al., 2015; Kuppens, Realo, & Diener, 2008; Miyamoto et al., 2013; Soto, Perez, Kim, Lee, & Minnic, 2011). More specifically, most studies have shown that the magnitude of the effect differs among European-Americans and East-Asians, whereby feeling negative is more strongly associated with poor physical and psychological health among the former than the latter.

Despite increased recognition of these differences in cultural perspective, a key question remains — when and how does culture moderate the link between negative emotion and wellbeing? To address this question of mechanism, we focus on the role of social norms regarding unhappiness, and test whether cultural differences in these norms (i.e., perceptions about the social desirability or appropriateness of feeling unhappy) explain variation in the strength of the unhappiness-wellbeing association across cultures.

### **A Normative Perspective on Culture**

In cultural research, there is increased interest in understanding the role that social norms play in a range of psychological processes (Chiu, Gelfand, Yamagishi, Shteynberg, & Wan, 2010; Morris, Hong, Chiu, & Liu, 2015). This has been driven in part by research showing that norms make a unique contribution to cultural variation above and beyond personal values and beliefs (Zou et al., 2010). Along these lines, research on cultural differences in emotion has highlighted the importance of investigating emotion norms. These norms have been found to shape emotional experiences, and cultures vary in their norms regarding the social desirability of positive and negative emotions (Bastian et al., 2012; Eid & Diener, 2001; Mesquita & Leu, 2007; Tsai, Knutson, & Fung, 2006). Thus, to understand cultural variation in the relationship between negative emotion and wellbeing, these lines of research suggest that it may be useful to adopt a norm-based approach to characterizing cultural influence.

Previous work has supported the importance of emotion norms by showing that people are aware of, and hold beliefs about, how socially desirable or appropriate it is to experience or express particular emotions (see Bastian, 2013, for a review; Eid & Diener,



2001; Stearns, 1994; Tsai et al., 2006). Indeed, unhappiness in Western culture is generally considered an undesirable emotion. One does not need to look hard in the Western world for evidence of the costs of unhappiness, and for messages devaluing unhappiness (e.g., thousands of self-help books and blog posts promoting the benefits of happiness, and consigning unhappiness to the category of “problem emotions”). This is further reflected in the eagerness of Western cultures to find the quick fix and rid oneself of the discomfort that unhappiness creates and receive instant relief. Indeed, the discomfort from experiencing unhappiness has been portrayed as easy to “cure” with a wide range of drugs and interventions designed to rapidly and efficiently help people return to “normality” (Bastian, 2013). It is not uncommon to hear people responding to a friend or loved one’s struggle with catchphrases like “just smile”, “look on the bright side”, or “don’t be so negative” (Harris, 2007). These salient cultural norms clearly communicate the unacceptability and undesirability of unhappiness — that one should not feel unhappy, and if you are unhappy (and not happy), there is something wrong with you (Bastian et al., 2012).

This line of work on the impact of social norms on emotional experience has found that social norms not to feel unhappy can affect how people respond to their unhappiness, and in turn, their wellbeing (Bastian et al., 2012, 2015). It has been argued that social norms not to feel unhappy ironically promote maladaptive responses to unhappy emotional experience, aggravating the unhappiness and reducing wellbeing (Bastian et al., 2012). Along these lines, norms communicating the undesirability of unhappiness may be a source of social pressure to not feel unhappy. This promotes negative self-evaluations when unhappiness is experienced which, in turn, amplifies these unwanted emotions and reduces wellbeing (Bastian, 2013; Bastian et al., 2012; Carver & Scheier, 1982; Moberly & Watkins, 2008). Avoidance or non-acceptance of unhappiness is another suggested maladaptive response to unhappy emotional experience promoted by these norms. Social norms not to feel unhappy may lead people to reject their own negative emotional experience, thereby amplifying these same unwanted emotions deemed to be socially undesirable and reducing wellbeing (Bastian et al., 2012; Hayes et al., 2004). However, where negative emotions are accepted, wellbeing is reported to be higher and associated with reduced negative affect and depression symptoms (Campbell-Sills, Barlow, Brown, & Hofmann, 2006; Kashdan, Barrios, Forsyth, & Steger, 2006; Shallcross, Troy, Boland, & Mauss, 2010). This is consistent with the growing evidence for interventions involving acceptance and mindfulness (e.g., Acceptance and Commitment Therapy, Mindfulness Based Cognitive Therapy), showing that non-reactive acceptance of

negative emotions leads to better wellbeing (Hofmann, Sawyer, Witt, & Oh, 2010; Ma & Teasdale, 2004).

Perhaps most pertinent to the present argument though, is evidence of cultural variation in social norms regarding negative emotions (Bastian et al., 2012; Eid & Diener, 2001). In Western cultures, the dominant cultural script is to value and encourage happiness, and to avoid unhappiness, with negative emotions like unhappiness often construed as harmful and a sign of an inability to control one's life (Kitayama, Markus, & Kurokawa, 2000; Kotchemidova, 2005; Ryan & Deci, 2001). By contrast, it has been proposed that in East-Asian contexts, the avoidance of unhappiness is less salient. Instead, the dominant cultural script is grounded in dialectical thinking, where reality is considered to be constantly changing and comprised of opposites and contradictions (Peng & Nisbett, 1999). In these cultures, happiness and unhappiness are seen to coexist and complement each other (Miyamoto & Ma, 2011; Spencer-Rodgers, Peng, & Wang, 2010). Along these lines, research has suggested that compared to Westerners, East-Asians are more likely to accept unhappiness as inevitable and part of reality, and may even perceive some desirable aspects of unhappiness (e.g., as a source of motivation to improve the self, or invite sympathy and support from others; Miyamoto, Ma, & Petermann, 2014; Uchida & Kitayama, 2009).

These findings suggest that the devaluation of unhappiness is much more normative within Western, relative to East-Asian, cultures. This raises the possibility that the costs to wellbeing of unhappiness (as outlined above) may be more apparent in Western than in East-Asian contexts. The theoretical case for this is strong and numerous researchers have posited cultural differences in beliefs about negative emotions as an explanatory mechanism for the moderating effect of culture on the negative emotion-wellbeing link (Bastian et al., 2012; Bastian, Kuppens, De-Roover, & Diener, 2014; Curhan et al., 2014; Miyamoto et al., 2013; Kuppens et al., 2008; Luong, Wrzus, Wagner, & Riediger, 2016).

Although a growing body of empirical work documents the moderating effect of culture on the negative emotion-wellbeing link, no studies have directly examined the desirability of negative emotions as a moderator in this relationship in cross-cultural contexts (i.e., unhappiness norms accounting for cultural variation in the wellbeing consequences of negative emotions). More importantly, only one study has explored cultural moderators of the relationship between negative emotion and wellbeing across nations; though the focus was not on cultural or emotion norms. This study, examining individual-level endorsement of individualism and collectivism, found negative emotions to be more strongly related to life satisfaction in individualistic nations than in collectivistic ones (Fischer et al., 2009; Kuppens

et al., 2008). Even though this finding provides some support for our reasoning, the individualism-collectivism distinction provides only a rather broad brush approach to cultural differences, and researchers have argued for a need to move beyond this dichotomy because it does not help to develop a comprehensive understanding of cultural differences in emotions (Ford & Mauss, 2015; Mesquita & Leu, 2007; Schimmack, Oishi, & Diener, 2002). Along these lines, for example, Ruby et al. (2012) found that cultural differences in individualism and collectivism could not explain cultural differences in ideal affect; suggesting that this distinction is not particularly helpful in understanding the experience of emotion.

### **The Present Study**

Building on these insights, we examine cultural norms as a potential mechanism underlying cultural differences in the association between negative emotion and wellbeing. Specifically, we focus on social norms regarding unhappiness (i.e., perceptions of how others, or society, view how socially desirable or appropriate it is to experience unhappiness). We focus on unhappiness norms and the link between unhappiness (i.e., the specific emotion, rather than negative emotions more generally) and wellbeing<sup>1</sup>, given the emphasis on not being unhappy in Western culture.

Our key prediction is that cultural differences in social norms for unhappiness will help explain cultural variation in the relative strength of the unhappiness-wellbeing link (see Figure 1). Unpacking this prediction, the first hypothesis is:

H1: Social norms for unhappiness will be lower in Western than in East-Asian cultures.

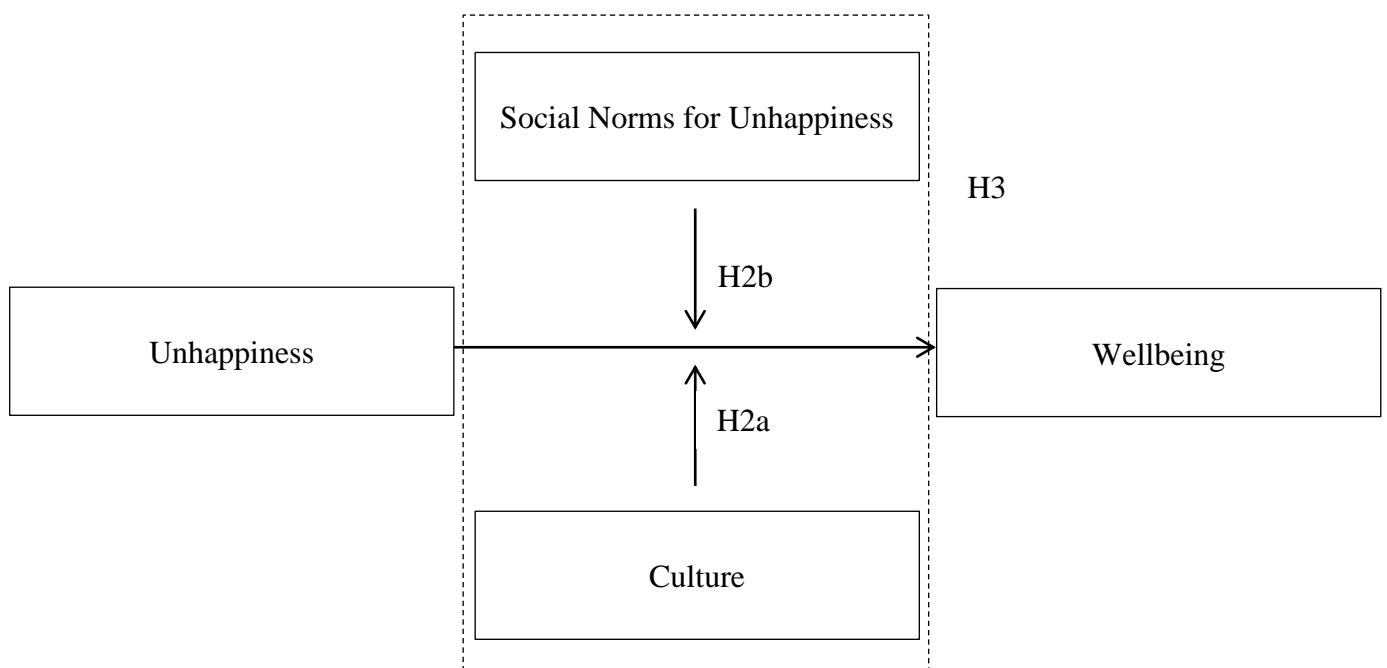
We then examine the extent to which culture versus emotion norms that characterize the influence of culture explain the relationship between experiences of unhappiness and wellbeing. Specifically, we anticipate that in Western contexts, experiences of unhappiness should be more costly to wellbeing because of the inclination for Westerners to perceive unhappiness as socially undesirable and to be avoided (i.e., unhappiness as counter-normative). Alongside this, we also expect that experiences of unhappiness should not be as costly to wellbeing among East-Asians because unhappiness would more typically be construed as socially desirable and acceptable, and part of normal reality. We investigate this prediction by including culture (H2a) and social norms for unhappiness (H2b) as moderators to the unhappiness-wellbeing link.

H2a: Culture will moderate the unhappiness-wellbeing link, whereby the association will be stronger in Western compared with East-Asian cultures.

H2b: Social norms for unhappiness will moderate the unhappiness-wellbeing link, with a stronger negative relationship between experiences of unhappiness and wellbeing among participants in contexts where unhappiness is counter-normative (i.e., less desirability of unhappiness), as opposed to when unhappiness is relatively more normative (i.e., more desirability of unhappiness).

Finally, we examine whether effects that have often been attributed to culture can be better explained by cultural differences in social norms for unhappiness. We predict that culture may mask the effects of cultural differences in social norms for unhappiness in explaining the unhappiness-wellbeing link. Therefore, when both moderating effects are examined at the same time, effects for culture should disappear because it is social norms for unhappiness and to a lesser extent culture that is driving these moderating effects of the unhappiness-wellbeing link.

H3: When both the statistical interaction between unhappiness and culture (H2a) and the statistical interaction between unhappiness and social norms for unhappiness (H2b) are considered simultaneously in an equation, we expect the former will not remain significant after accounting for the latter.



*Figure 1.* The proposed model for understanding mechanism accounting for cultural differences in the wellbeing consequences of experiences of unhappiness.

## Method

### Participants

**East-Asian Participants.** Participants were 205 undergraduate students aged 17-23 from a large university in China (96 males, 109 females). Participants were recruited by randomly selecting students attending three undergraduate lectures and participation was voluntary. East-Asian participants were on average 20.1 years old ( $SD = 1.05$ ) and all described their ethnicity as Chinese.

**Western Participants.** Participants were 176 undergraduate students aged 18-25 recruited from a psychology research pool at a large Australian university (53 males, 123 females). Participants received course credit for their participation. On average, participants were 18.9 years old ( $SD = 1.35$ ) and all described their ethnicity as Caucasian.

### Measures

Participants in both countries were provided with the same questionnaire, with back translation procedures used for the Chinese version.

**Frequency of Unhappiness.** Participants were asked to indicate the frequency of their experience of the emotion, unhappy, “*How often have you experienced the following emotion during the past month*”<sup>2</sup>. This item was rated on a 9-point scale (1=*None of the time*, 9=*All of the time*).

**Wellbeing.** Two measures indexed this construct.

***The Center for Epidemiologic Studies Depression Scale – Shortened Version.*** (CESD-10; Andresen, Malmgren, Carter, & Patrick, 1994). Ten items (e.g., “I had trouble keeping my mind on what I was doing”) assessed depression symptoms (East-Asian,  $\alpha = .79$ ; Western,  $\alpha = .84$ ). Participants were asked to indicate how much the items had applied to them during the past week on a scale ranging from 0=*Rarely or none of the time*, to 3=*Most or all of the time*.

***Satisfaction with Life Scale.*** (SWLS; Diener, Emmons, Larsen, & Griffin, 1985). Five items (e.g., “I am satisfied with my life”) assessed one's judgment of satisfaction with one's life (East-Asian,  $\alpha = .75$ ; Western,  $\alpha = .85$ ). Each item was rated on a 7-point scale (1=*Strongly disagree*, 7=*Strongly agree*).

**Social Norms for Unhappiness.** This was assessed with three items, including “In your society, what is a desirable amount of unhappiness to experience”: 0=*0 percent*, to 100=*100 percent*, “In your society, how often would one ideally want to experience unhappiness”: 0=*none of the time*, to 100=*all of the time*, and “In your society, what is an

ideal intensity of unhappiness that one would want to experience”: 0=*very low*, to 100=*very high*”. The responses were summed (East-Asian,  $\alpha = .73$ ; Western,  $\alpha = .69$ ). Similar items have been used in previous research (Bastian et al., 2014; Eid & Diener, 2001)<sup>3</sup>.

## Results

### Cross-cultural Measurement Invariance

We conducted multi-group confirmatory factor analysis to examine measurement equivalence of the social norms for unhappiness measure across cultures. As the social norms for unhappiness measure consists of only three items, it was examined with the depression measure as a correlated two-factor model. Model fit was evaluated with the comparative fit index (CFI) and the standardized root mean square residual (SRMR): CFI values between 0.90-0.95 or above and SRMR values of below 0.08 were used as indicators of acceptable model fit (Hu & Bentler, 1998). First, we assessed configural invariance, and then we constrained factor loadings to be equal across cultures and assessed metric invariance using the chi-square difference test and the cut-off of CFI change lower than 0.01 (Cheung & Rensvold, 2002). We next examined measures for scalar invariance by constraining the intercepts to be equal across cultures.

The configural invariance model had acceptable fit,  $\chi^2(128) = 223.74$ ,  $p < .001$ ; CFI = 0.92; SRMR = 0.06. After constraining factor loadings across cultures, the metric invariance model fit was also acceptable,  $\chi^2(139) = 240.12$ ,  $p < .001$ ; CFI = 0.91; SRMR = 0.07. Demonstrating metric invariance, the constrained and unconstrained models did not differ significantly,  $\Delta\chi^2(11) = 16.38$ ,  $p = 0.13$ ,  $\Delta\text{CFI} = 0.005$ . Full scalar invariance could not be established, but partial scalar invariance was demonstrated by relaxing five constraints on the intercepts, and the model had acceptable fit,  $\chi^2(145) = 251.61$ ,  $p < .001$ ; CFI = 0.91; SRMR = 0.07. The metric invariance and partial scalar invariance models did not significantly differ in model fit,  $\Delta\chi^2(6) = 11.49$ ,  $p = 0.07$ ,  $\Delta\text{CFI} = 0.005$ . Taken together, configural, metric, and partial scalar invariance of measures were demonstrated, indicating that correlations and means of these measures could be compared meaningfully across cultures<sup>4</sup>.

### Cultural Differences in Unhappiness Norms

Descriptive statistics for the sample by culture are provided in Tables 1 and 2. Consistent with H1, Western participants ( $M = 17.22$ ,  $SD = 13.00$ ) endorsement of social norms for unhappiness was significantly lower than that for East-Asian participants ( $M = 36.53$ ,  $SD = 16.37$ ),  $t(372) = 12.74$ ,  $p < .001$ ,  $d = 1.31$ .

Table 1  
*Descriptive Statistics as a Function of Culture. N = 381.*

Variable	Western Participants		East-Asian Participants	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1. Frequency of Unhappiness	4.23	1.69	3.35	1.67
2. Wellbeing: Depression	0.99	0.57	0.94	0.52
3. Wellbeing: Life Satisfaction	4.84	1.23	3.56	1.10
4. Social Norms for Unhappiness	17.22	13.00	36.53	16.37

Table 2  
*Correlations as a Function of Culture. N = 381.*

Variable	Western Participants				East-Asian Participants			
	1	2	3	4	1	2	3	4
1. Frequency of Unhappiness	--	0.63**	-0.43**	0.03	--	0.32**	-0.10	0.25**
2. Wellbeing: Depression		--	-0.53**	-0.01		--	-0.18*	0.34**
3. Wellbeing: Life Satisfaction			--	0.03			--	0.03
4. Social Norms for Unhappiness				--				--

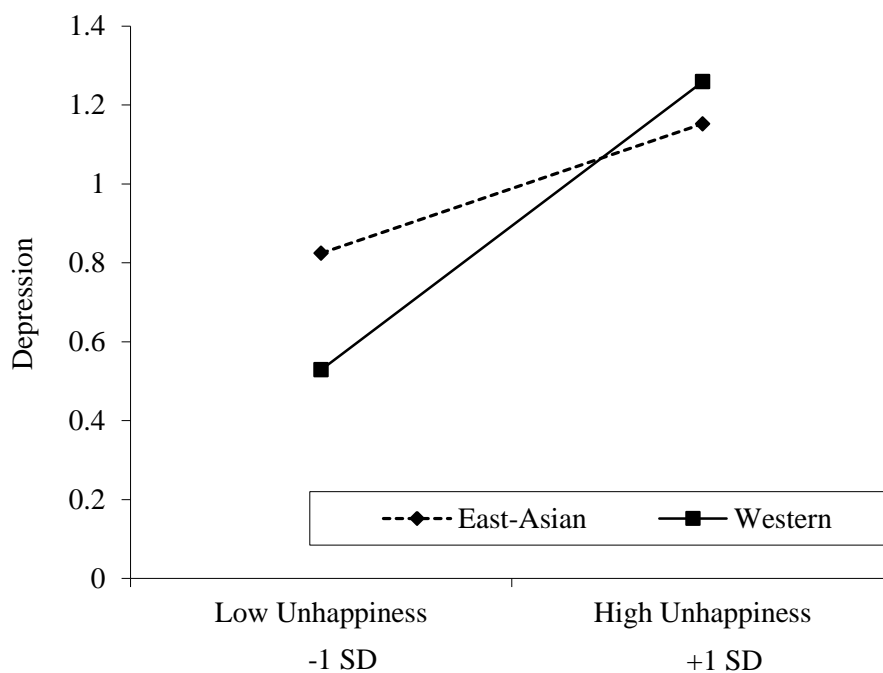
\*  $p < .05$ , \*\*  $p < .01$

### **Culture Differences in the Unhappiness-wellbeing Link**

Two hierarchical regression analyses were conducted to examine the influence of culture (East-Asian versus Western) as a moderator of the relationship between unhappiness and wellbeing (i.e., depression, life satisfaction; H2a). Unhappiness and culture were added

in Step 1, followed by the interaction term in Step 2. To ensure that multicollinearity between predictors and interaction term did not affect the results, each variable was first mean-centred and the interaction term was based on the centred scores (see Aiken & West, 1991).

In the first analysis with depression as the outcome variable, results showed that unhappiness,  $\beta = 0.50$ ,  $t(371) = 10.73$ ,  $p < .001$ , but not culture,  $\beta = -0.09$ ,  $t(371) = -1.86$ ,  $p = .063$ , significantly predicted depression. As hypothesized, the interaction between unhappiness and culture was significant,  $\beta = 0.18$ ,  $t(371) = 3.97$ ,  $p < .001$ . Simple slopes analysis revealed that unhappiness was more strongly associated with higher levels of depression for Western participants,  $\beta = 0.68$ , 95% CI [.542, .805],  $t(371) = 10.14$ ,  $p < .001$ , than for East-Asian participants,  $\beta = 0.31$ , 95% CI [.160, .465],  $t(371) = 4.91$ ,  $p < .001$  (see Figure 2). Results also showed that the confidence intervals of the standardized beta weights did not overlap, suggesting that the standardized beta weights were significantly different from each other (Cumming, 2009).



*Figure 2.* Cultural moderation of the association between unhappiness and depression;  $N = 381$ .

In the second analysis with life satisfaction as the outcome variable, unhappiness,  $\beta = -0.24$ ,  $t(371) = -5.48$ ,  $p < .001$ , and culture,  $\beta = 0.55$ ,  $t(371) = 12.34$ ,  $p < .001$ , each significantly predicted life satisfaction. Consistent with H2a, the interaction term was significant,  $\beta = -0.15$ ,  $t(371) = -3.56$ ,  $p < .001$ . Simple slopes analysis revealed that



unhappiness was associated with lower levels of life satisfaction for Western participants,  $\beta = -0.40$ , 95% CI [-.535, -.272],  $t(371) = -6.23$ ,  $p < .001$ , but not for East-Asian participants,  $\beta = -0.09$ , 95% CI [-.221, .034],  $t(371) = -1.40$ ,  $p = .162$  (see Figure 3).

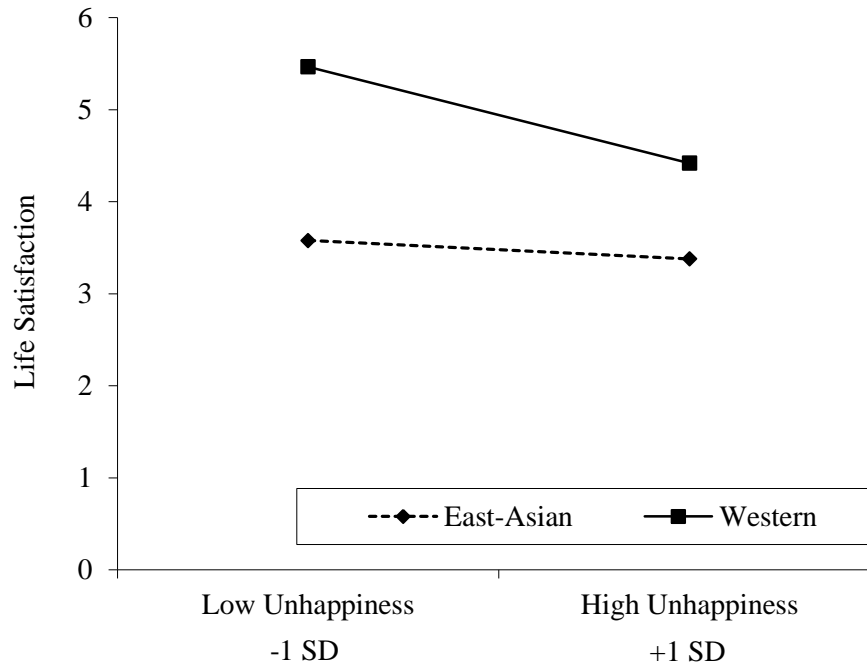


Figure 3. Cultural moderation of the association between unhappiness and life satisfaction;  $N = 381$ .

### Testing the Moderating Effect of Unhappiness Norms on the Unhappiness-wellbeing Link

To test whether social norms for unhappiness moderated the relationship between unhappiness and wellbeing (i.e., depression, life satisfaction; H2b), two further hierarchical regression analyses were conducted. Unhappiness and unhappiness norms were added in Step 1, followed by the interaction term in Step 2.

Analysis with depression as the outcome variable revealed that unhappiness,  $\beta = 0.47$ ,  $t(367) = 10.64$ ,  $p < .001$ , and unhappiness norms,  $\beta = 0.17$ ,  $t(367) = 3.88$ ,  $p < .001$ , each significantly predicted depression, and consistent with H2b, the interaction term was significant,  $\beta = -0.22$ ,  $t(367) = -4.78$ ,  $p < .001$ . Simple slopes analysis revealed that unhappiness was more strongly associated with higher levels of depression in contexts where unhappiness was counter-normative (i.e., less desirability of unhappiness),  $\beta = 0.65$ , 95% CI [.515, .765],  $t(367) = 10.91$ ,  $p < .001$ , as opposed to when unhappiness was relatively more normative (i.e., more desirability of unhappiness),  $\beta = 0.30$ , 95% CI [.162, .413],  $t(367) =$

5.36,  $p < .001$  (see Figure 4). Results also showed that the confidence intervals of the standardized beta weights did not overlap, suggesting that the standardized beta weights were significantly different from each other (Cumming, 2009).

Analysis with life satisfaction as the outcome variable showed that unhappiness,  $\beta = -0.10$ ,  $t(367) = -2.01$ ,  $p = .045$ , and unhappiness norms,  $\beta = -0.25$ ,  $t(367) = -5.00$ ,  $p < .001$ , each significantly predicted life satisfaction. However, the interaction term was not significant,  $\beta = 0.08$ ,  $t(367) = 1.63$ ,  $p = .104$ .

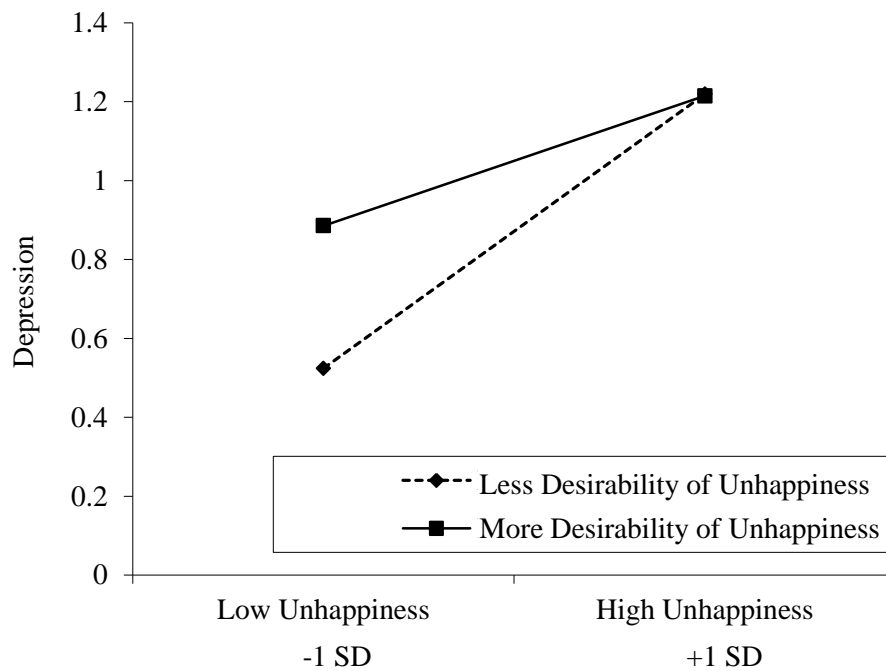


Figure 4. Depression ratings as a function of unhappiness and unhappiness norms;  $N = 381$ .

### Cultural Differences in Unhappiness Norms Account for the Cultural Moderation of the Unhappiness-wellbeing Link

To examine whether unhappiness norms can account for the moderating effect of culture on the relationship between unhappiness and wellbeing (H3), a hierarchical multiple regression analysis was conducted. Unhappiness, culture, and the interaction between unhappiness and culture were entered in Step 1 with depression as the outcome variable. In Step 2, unhappiness norms and the interaction between unhappiness and unhappiness norms were entered. Similar to the regression analyses conducted above, each variable was first mean-centred and the interaction terms were based on the centred scores to ensure that multicollinearity between predictors and interaction term did not affect the results. We further

checked the variance inflation factor (VIF; the extent to which multicollinearity among input variables is present in a regression analysis), and the VIF of all input variables were less than 5 (with the highest VIF = 1.85), suggesting satisfactory VIF and interpretable regression coefficients.

From Table 3, it can be seen that although the interaction between unhappiness and culture emerged as a significant predictor of depression at Step 1,  $\beta = 0.17, p < .001$ , this effect became non-significant at Step 2,  $\beta = 0.08, p = .214$ , when the interaction between unhappiness and unhappiness norms was included. This suggests that the interaction between unhappiness and unhappiness norms accounted for the variance explained by the interaction between unhappiness and culture. Furthermore, at Step 2, only the interaction between unhappiness and unhappiness norms emerged as a significant predictor of depression,  $\beta = -0.17, p = .006$ .

Table 3

*Hierarchical Multiple Regression Analysis Predicting Depression. N = 381.*

Step	Predictor	$R^2$	$R^2$ change	Sig.	$\beta$	$p$
1	Unhappiness	.246	.246	<.001	0.491	<.001**
	Culture				-0.091	0.053
	Unhappiness x Culture				0.167	<.001**
2	Unhappiness	.279	.034	<.001	0.477	<.001**
	Culture				-0.010	0.862
	Unhappiness x Culture				0.075	0.214
	Unhappiness Norms				0.171	0.002**
	Unhappiness x Unhappiness Norms				-0.166	0.006**

\*  $p < .05$ , \*\*  $p < .01$

As a robust analysis, we further tested H3 with a mediated moderation analysis (Hayes, 2013, model 15). Culture was included as a predictor, with depression as the outcome variable. Unhappiness norms were entered as a mediator, and unhappiness was entered as the moderator. Analysis revealed no significant effect of culture,  $B = -0.01, 95\% \text{ CI} [-0.062, .051], t = -0.19, p = .847$ , on depression, but unhappiness,  $B = 0.15, 95\% \text{ CI} [.116, .180], t = 9.02, p < .001$ , and unhappiness norms,  $B = 0.01, 95\% \text{ CI} [.002, .009], t = 3.00, p = .003$ , each significantly predicted depression. Consistent with the results of the hierarchical multiple regression analysis, the interaction between unhappiness and

unhappiness norms,  $B = -0.002$ , 95% CI  $[-.004, -.0004]$ ,  $t = -2.42$ ,  $p = .016$ , but not the interaction between unhappiness and culture,  $B = 0.02$ , 95% CI  $[-.018, .066]$ ,  $t = 1.13$ ,  $p = .260$ , significantly predicted depression. Importantly, results showed that the test of mediated moderation was significant,  $B = 0.02$ , 95% CI  $[.005, .043]$ , suggesting that unhappiness norms help account for the cultural moderation of the unhappiness-wellbeing link.

As unhappiness norms did not moderate the association between unhappiness and life satisfaction, no hierarchical multiple regression analysis was conducted with life satisfaction as the outcome variable.

### **Sensitivity Analyses**

Further sensitivity analyses were also conducted. First, a hierarchical multiple regression analysis was conducted in which unhappiness, unhappiness norms, and the interaction between unhappiness and unhappiness norms were entered in Step 1 with depression as the outcome variable. In Step 2, culture and the interaction between unhappiness and culture were entered. Step 1 (i.e., unhappiness, unhappiness norms, and the interaction between them) accounted for a significant proportion of variance in depression,  $R^2$  change = 0.28,  $F$  change = 46.63,  $p < .001$ . At Step 2, the interaction between unhappiness and culture did not result in a further significant increase in variance explained,  $R^2$  change = 0.003,  $F$  change = 0.82,  $p = .441$ . Second, the analysis conducted did not reveal a three-way interaction (i.e., Unhappiness x Culture x Unhappiness Norms),  $\beta = -0.07$ ,  $t(363) = -0.91$ ,  $p = .361$ . Third, to ensure that age and gender did not account for any of the effects, these were entered as control variables in all the analyses reported above. Adding these covariates produced comparable results yielding the same conclusions.

### **Discussion**

Although a growing body of literature documents cultural differences in the negative emotion-wellbeing association (e.g., Curhan et al., 2014; Kitayama et al., 2015; Kuppens et al., 2008; Miyamoto et al., 2013), few studies have explored mechanisms that can help account for this cultural variation. In this current research, we therefore adopted a cultural norm approach and explored social norms for unhappiness as the mechanism. Overall, our findings suggest that cultural differences in unhappiness norms can help account for variation in the strength of the relationship between unhappiness and wellbeing (i.e., depression) across cultures. In doing so, the present research is among the first to provide a demonstration of particular aspects of culture that are responsible for the wellbeing consequences of negative emotion.

Consistent with H1, we found that social norms for unhappiness were significantly lower in Western than in East-Asian cultures. In keeping with previous research (Bastian et al., 2012; Eid & Diener, 2001), this suggests that culture shapes how normative it is to feel unhappy, with greater devaluation of unhappiness in Western compared to East-Asian contexts. That is, cultural differences exist in how unhappiness is construed – such that unhappiness is viewed as more undesirable, unacceptable, and problematic in Western, compared with East-Asian, cultures.

In line with H2a and previous research, we replicated the moderating effect of culture on the association between negative emotion and wellbeing. Specifically, we found an attenuated negative link between experiences of unhappiness and wellbeing (i.e., higher depression, lower life satisfaction) among East-Asians, relative to Westerners. This highlights that unhappiness is not universally experienced as aversive; cultural contexts not only shape the subjective experience of unhappiness, but also influence the degree to which unhappiness is associated with reduced wellbeing.

Additionally, we found that social norms for unhappiness moderated the strength of the relationship between experiences of unhappiness and depression (H2b). That is, experiences of unhappiness were more strongly associated with depression in contexts where unhappiness was perceived to be socially undesirable and inappropriate (i.e., unhappiness was counter-normative). This is in line with research which has found that norms communicating the undesirability of unhappiness may lead individuals experiencing unhappiness to negatively self-evaluate and avoid unhappiness, thereby amplifying the negative emotions and reducing wellbeing (Bastian, 2013; Bastian et al., 2012; Hayes et al., 2004). However, unhappiness norms did not moderate the link between experiences of unhappiness and life satisfaction. Although counter to our hypothesis, these findings are consistent with the only other two studies directly examining this moderating effect of unhappiness norms (albeit not examining cultural variation in the unhappiness-wellbeing link; Bastian et al., 2014; Luong et al., 2016). In a study investigating a similar construct (i.e., negative affect valuation, focusing on individual-level values as opposed to collective-level norms), Luong et al. (2016) found that negative affect valuation moderated the association between negative emotion and emotional health (including depression) but not life satisfaction. Similarly, Bastian et al. (2014) found that social valuation of negative emotions did not moderate the relationship between experiences of negative emotions and life satisfaction. As Luong et al. (2016) argue, this null result may be the consequence of perceived life satisfaction involving the synthesis of many diverse pieces of information, and

therefore, individuals may draw on more easily accessible and salient information (i.e., current affective experience) to inform this evaluation. Consequently, this does not allow for social norms for unhappiness to play as strong a role in the unhappiness-wellbeing association (Kahneman, 2011; Schwarz & Clore, 2003).

Together, these findings show that experiences of unhappiness are more strongly associated with reduced wellbeing in cultural contexts where unhappiness is counter-normative. More specifically, our findings suggest that unhappiness is more costly to individual wellbeing in Western cultures because unhappiness is viewed as more undesirable and problematic. Conversely, in East-Asian contexts, unhappiness may take less of a toll on individual wellbeing because unhappiness is construed as more desirable and acceptable. This implies that the cultural moderation of the unhappiness-wellbeing link may be explained by cultural differences in social norms for unhappiness. We examined this in H3. The novel finding here was that in a hierarchical multiple regression analysis, the initial significant moderating effect of culture on the relationship between unhappiness and wellbeing was rendered non-significant after the inclusion of the moderating effect of social norms for unhappiness, suggesting that cultural differences in unhappiness norms are at least partially responsible for the cultural moderation of the unhappiness-wellbeing link. This is further supported by the findings from our mediated moderation analysis. Importantly, taken together, the findings support our argument that cultural variability in the association between negative emotion and wellbeing is due to cultural differences in unhappiness norms. In other words, the commonly demonstrated cultural differences in the negative emotion-wellbeing link may reflect cultural variations in how unhappiness is construed.

Clearly, the current study is not without limitations. First, although our interpretation of the findings are consistent with theoretical arguments and empirical findings in the literature (e.g., Curhan et al., 2014; Kitayama et al., 2015; Luong et al., 2016; Miyamoto et al., 2013), the cross-sectional nature of the data does not permit us to make causal inferences about the directionality of effects. Future research is needed to disentangle causal pathways. Second, in examining the explanatory mechanism for cultural differences in the negative emotion-wellbeing link, we focused only on one negative emotion – unhappiness – and social norms regarding unhappiness. Thus, future work should explore and replicate the findings with other discrete negative emotions (e.g., anger; Kitayama et al., 2015). In pursuing this, it is worth noting that considerable cultural variation has been found in the strength of the association between negative emotions and physical health (e.g., self-reported health status, objective health measures such as biomarkers; Curhan et al., 2014; Miyamoto et al., 2013),

and so, it may be important to include physical health in the investigation. A third potential criticism of our work, and indeed that of others in the field who have used a similar approach to examine the emotion-wellbeing link (Kuppens et al., 2008; Leu, Wang, & Koo, 2011; Luong et al., 2016), is that differentiating positive and negative emotions from wellbeing (i.e., depression, life satisfaction) may be challenging in light of their high inter-correlation. However, research has found that life satisfaction can be discriminable from both positive and negative emotions (Lucas, Diener, & Suh, 1996).

Previous research has suggested social norms regarding unhappiness provide both a highly plausible and theoretically grounded account of the moderating effect of culture on the negative emotion-wellbeing link. This study provides some of the first empirical evidence to support this prediction. Additionally, our findings highlight that in order to understand the degree to which unhappiness will exert a toll on wellbeing (i.e., depression), it is important to take cultural norms about the value of unhappiness into consideration. That is, individuals who experience frequent unhappiness may be disadvantaged in contexts that devalue unhappiness (i.e., unhappiness is counter-normative). As we will all inevitably experience negative emotions like unhappiness from time to time, this has important implications for long-term wellbeing and mental health. Our findings suggest that communicating social norms regarding the acceptability of unhappiness may buffer against the harmful effects of unhappiness on wellbeing. In Western society, where there is greater intolerance for unhappiness, this message that feeling unhappy is acceptable and a normal part of life may be especially powerful.

## Footnotes

<sup>1</sup> As our goal was to examine social norms regarding unhappiness in greater detail, we focused on the association between unhappiness (i.e., a discrete emotion) and wellbeing, rather than negative emotions as a whole. This was done to avoid lumping discrete emotions into two broad categories of positive emotions and negative emotions, which may be problematic (Harmon-Jones, Bastian, & Harmon-Jones, 2016; Scollon & Tov, 2012). In fact, avoiding characterizing emotions as simply positive or negative is especially important in cross-cultural contexts, where what is positive or negative may vary (e.g., pride; Scollon, Diener, Oishi, & Biswas-Diener, 2004).

<sup>2</sup> Previous research has also used a single item to measure the frequency of specific emotions without lumping them into two broad categories of positive emotions and negative emotions (Scollon et al., 2004).

<sup>3</sup> These data were part of a larger study that included measure of social expectancies for experiencing positive emotions.

<sup>4</sup> We also examined social norms for unhappiness measure and life satisfaction measure as a correlated two-factor model. The configural invariance model had acceptable fit,  $\chi^2(38) = 87.00, p < .001$ ; CFI = 0.94; SRMR = 0.05. After constraining factor loadings across cultures, the metric invariance model fit was also acceptable,  $\chi^2(44) = 99.22, p < .001$ ; CFI = 0.94; SRMR = 0.07. Demonstrating metric invariance, the constrained and unconstrained models did not differ significantly,  $\Delta\chi^2(6) = 12.23, p = 0.06, \Delta\text{CFI} < 0.01$ . Full scalar invariance could not be established, but partial scalar invariance was demonstrated by relaxing three constraints on the intercepts, and the model had acceptable fit,  $\chi^2(47) = 100.67, p < .001$ ; CFI = 0.94; SRMR = 0.07. The metric invariance and partial scalar invariance models did not significantly differ in model fit,  $\Delta\chi^2(3) = 1.45, p = 0.69, \Delta\text{CFI} = 0.001$ .



## Chapter 5: The More (Social Group Memberships), the Merrier: Is this the Case for Asians?<sup>5</sup>

### Abstract

While previous studies have consistently shown that belonging to multiple groups enhances wellbeing, the current research proposes that for Asians, multiple group memberships (MGM) may confer fewer wellbeing benefits. We suggest that this is due, in part, to Asian norms about relationships and support seeking, making Asians more reluctant to enlist social support due to concerns about burdening others. Overall, MGM was associated with enhanced wellbeing in Westerners (Study 2), but not Asians (Studies 1, 2, 3). Study 2 showed that social support mediated the relationship between MGM and wellbeing for Westerners only. In Study 3, among Asians, MGM benefited the wellbeing of those who were least reluctant to enlist support. Finally, reviewing the MGM evidence-base to date, relative to Westerners, MGM was less beneficial for the wellbeing of Asians. The evidence underscores the importance of culture in influencing how likely individuals utilize their group memberships as psychological resources.

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<sup>5</sup> In this chapter, we examined the effect of multiple group memberships on a range of wellbeing indicators.

### **The More (Social Group Memberships), the Merrier: Is this the Case for Asians?**

We know that social relationships matter for psychological wellbeing. The research shows that people who belong to more social groups have better psychological wellbeing than those with fewer social group memberships (Brook, Garcia, & Fleming, 2009; Cruwys et al., 2013; Haslam et al., 2008; Helliwell, 2003; Jetten et al., 2015; Sani, Madhok, Norbury, Dugard, & Wakefield, 2015a; Thoits, 1983). This is due, in part, to social groups providing an important means to access psychological resources such as social support (see Jetten, Haslam, Halam, Dingle, & Jones, 2014). Social support, in turn, has been found to be associated with mental health benefits that include better adjustment to stressful events (House, Landis, & Umberson, 1988; Thoits, 1995). It follows logically then, that the more groups an individual belongs to, the more potential social support resources they have at their disposal when encountering challenges or stressors in their life.

Although much of the empirical work on multiple group membership and wellbeing has generated important insights, these studies have been conducted primarily in Western societies and it remains to be examined whether the findings generalize to non-Western cultures (Henrich, Heine, & Norenzayan, 2010). Put simply, will “the more the merrier” effect, in the case of multiple groups, hold for Asians? There are good reasons to believe that such findings may not easily generalize to Asian populations. For example, studies have suggested that cultural norms about relationships in the Asian cultures could make Asians more sensitive to the negative relational consequences of support seeking when compared to European Americans (e.g., burdening others, disrupting group harmony; Kim, Sherman, Ko, & Taylor, 2006; Kim, Sherman, & Taylor, 2008; Taylor et al., 2004). To the extent that this applies, multiple group memberships may not be associated with greater support seeking in times of difficulty and stress for Asians. These cultural differences in the role that multiple group memberships play raise questions about the nature of its relationship with psychological wellbeing in Asian cultures. Addressing this issue, the present research examines the role of multiple group memberships in Asian and Western contexts.

#### **Multiple Group Memberships and Wellbeing — ‘The More the Merrier’**

The social identity approach to health (Haslam, Jetten, Postmes, & Haslam, 2009; Jetten, Haslam, & Haslam, 2012; Jetten et al., 2014) provides an explanation for the relationship between multiple group memberships and wellbeing. Fundamental to this approach is the idea that social group memberships are critical in initiating a shared sense of identification. When social groups are perceived as meaningful and relevant to characterizing the self, they become psychologically internalized and help to understand the self and one’s

place in the world (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). Hence, social groups have the power to furnish people with a sense of themselves as part of a larger collective (“us”) rather than as merely unique individuals (“I”; Turner, 1982).

Accordingly, when one incorporates groups of others (e.g., one’s family, friendship, community, and recreational groups) into one’s sense of self, one will feel *psychologically connected* with those others, such that their interests become one’s own (Haslam, Reicher, & Levine, 2012). More importantly still, such internalized group membership provides a meaningful basis to receive and benefit from various forms of social support (Cohen & Wills, 1985; Haslam, 2004; Haslam et al., 2009; Postmes & Branscombe, 2002; Underwood, 2000). This means that it is only when people perceive themselves to share a mutual sense of common group membership with others that they are more likely to give, and be open to receiving, support and other resources from them; facilitating constructive helping between individuals. Applying this logic, social groups should only enhance positive social support and wellbeing when (and to the extent that) individuals *identify* strongly with them. A large body of empirical work has substantiated this by showing that shared identity is indeed what makes social support possible and effective (e.g., Haslam, 2004; Haslam, O’Brien, Jetten, Vormedal, & Penna, 2005; Haslam et al., 2012; Levine, Prosser, Evans, & Reicher, 2005). For illustration, in a study by Haslam et al. (2005), it was found that shared group memberships had a positive impact on wellbeing among hospital patients recovering from heart surgery because such group memberships served as a basis for the receipt of effective support from others.

Following from this, the social identity approach to health posits that if group membership serves as a psychological resource (e.g., providing a basis for social support), then it is likely that multiple group memberships should enhance this resource (Cruwys, Haslam, Dingle, Haslam, & Jetten, 2014; Haslam et al., 2008; Jetten et al., 2015). Individuals who belong to multiple groups are therefore likely to have more potential sources from which to draw social support in times of difficulty and stress, in turn protecting and enhancing their wellbeing (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009; Jetten et al., 2014; Jetten, Haslam, Iyer, & Haslam, 2009). Indeed, several studies have consistently shown that having more group memberships (e.g., belonging to family, friendship, community, recreational groups) is associated with greater psychological wellbeing.

For example, in one study conducted with individuals who had recently experienced a stroke, Haslam et al. (2008) showed that life satisfaction and wellbeing were higher for those who belonged to more social groups before their stroke. Furthermore, belonging to multiple

groups has also been found to be protective against developing depression (Cruwys et al., 2013), and to be associated with reduced depression and distress among university students and healthy adults during times of important life transitions (Iyer et al., 2009; Linville, 1985, 1987; Thoits, 1983). Along these lines, a longitudinal study with British students entering university showed that having a greater number of group memberships before the move to university predicted better adjustment and wellbeing once students had been at university for a few months (Iyer et al., 2009). Moreover, there was a clear relationship between the numbers of groups that these students were members of and the amount of social support they reported receiving, such that multiple group memberships provided individuals with more sources of support that could be drawn on to provide stability in this period of transition. While the aforementioned studies involved correlational or longitudinal examinations, the beneficial effect of multiple group memberships has also been demonstrated experimentally by manipulating the psychological availability of group memberships (i.e., getting participants to think of one, three, or five group memberships; Jones & Jetten, 2011, Study 2).

However, the relationship between multiple group memberships and wellbeing has mostly been demonstrated in Western cultural contexts. This is important because research suggests that individuals in Asian cultural contexts may not utilize their multiple group memberships in the same way as individuals in Western cultural contexts. We therefore question the generalizability of the multiple group membership effect and ask in this research whether group memberships play a different role in Asian cultures.

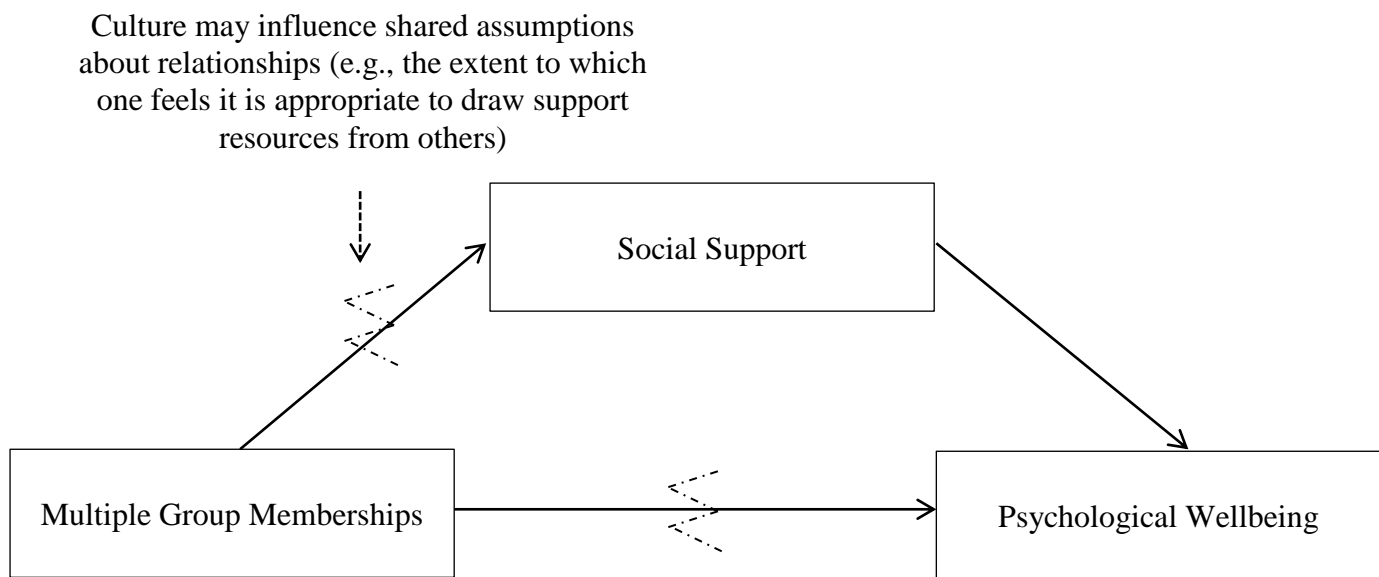
### **Multiple Group Memberships and Wellbeing: A Cross-cultural Perspective**

Research has shown that there is cultural variation in how people construe the self and their relationships with others (e.g., relative emphasis on personal goals or group goals; Markus & Kitayama, 1991), and in turn, their expectations of those relationships. In Western contexts, individualism is emphasized, and individuals are encouraged to promote their uniqueness and act according to their own volition (Heine, Lehman, Markus, & Kitayama, 1999). By contrast, the emphasis is on collectivism in Asian contexts. Individuals in these contexts are encouraged to maintain closeness and harmony within social groups and view group goals as primary and personal beliefs, needs, and goals as secondary (Heine et al., 1999; Markus & Kitayama, 1991). These differences in cultural norms and expectations about relationships are likely to impact on the extent to which individuals seek social support (Kim et al., 2006; Sherman, Kim, & Taylor, 2009; Taylor et al., 2004). Specifically, in Asian cultures, individuals are more careful with regards to extracting support from others because they are more concerned about the potential negative relational implications of support

seeking (Kim et al., 2008). That is, social support seeking in this cultural context is more likely to be seen as an imposition, burdening the provider of the support because drawing on another person for support can tax that other person's time and attention resources (Seidman, Shrout, & Bolger, 2006). This can also be costly in the sense that it may undermine and disrupt group harmony. In contrast, individuals in Western cultures view social support as personal resources, making them more likely to actively solicit them in times of difficulty (Chen, Kim, Mojaverian, & Morling, 2012; Uchida, Kitayama, Mesquita, Reyes, & Morling, 2008).

Evidence supporting this argument comes from Taylor et al. (2004) who showed that Asians were less willing than European Americans to draw on social support from their social networks to cope with stress. Furthermore, they found Asians to be more sensitive to the relational consequences of support seeking than Americans, and that these relational concerns accounted for the cultural differences in the use of social support for coping with stress. This suggests that among Asians, cultural norms (e.g., concerns about burdening others) could discourage the active engagement of one's social support network to cope with stress.

Building on these previous findings, to the extent that multiple group memberships are seen as another form of relationship with others (Jetten et al, 2015), it is likely that cultural variation in shared assumptions about relationships and support seeking may influence the way individuals utilize their multiple group memberships. Specifically, this may affect the degree to which one feels it is appropriate to draw upon support resources derived from shared group memberships, which would in turn influence one's wellbeing. Consequently, multiple group memberships may confer fewer benefits to the psychological wellbeing of Asians because cultural norms on relationships and support seeking in Asian cultural contexts might lead to reluctance to tap into social support resources from their group memberships (see Figure 1). Importantly, this line of work extends on previous research examining cultural differences that has focused largely on relationships and support seeking from significant individuals (e.g., a family member, friend; Kim et al., 2008). Here, we consider the particular contribution that relationships and social support from groups of others makes to health and wellbeing — where group memberships can comprise a range of diverse relationships such as those with family and friendship groups as well as religious, community, and recreational groups. More importantly, we focus on those group memberships that are meaningful and which individuals feel psychologically connected to (i.e., social identification; Jetten et al., 2014).



*Figure 1.* Proposed relationship between multiple group memberships and wellbeing, with breaks indicated where we hypothesize the relationship to be weaker among Asians than among Westerners.

### The Present Research

In four studies, we investigated the extent to which cultural normative expectations about support seeking would influence the degree to which individuals derive psychological resources and wellbeing benefits from belonging to multiple groups. We examined the effect of multiple group memberships on a wide range of wellbeing indicators — notably, life satisfaction, happiness, depression, anxiety, and stress. Study 1 used an exploratory correlational design to examine the role that multiple group memberships play in the wellbeing of Asians. In Studies 2 and 3, we investigated a potential cultural underpinning that might account for why individuals from different cultures (Asian versus Western) may utilize their group membership resources in different ways. Here, we predicted cross-cultural variation in drawing on support from shared group memberships, such that reluctance to enlist support from relationships may lead to fewer support resources being derived from belonging to multiple groups. Lastly, to examine the robustness of the relationship between multiple group memberships and wellbeing in different cultural contexts, we conducted a review of the empirical literature assessing this cross-sectional relationship (contrasting Asians with Westerners) in Study 4.

## Study 1

In a first exploratory correlational study, we aimed to explore the relationship between multiple group memberships and psychological wellbeing among international Asian students who had just transitioned from their own culture to a Western culture to commence their studies.

Ethical clearance for all studies was provided by the Psychology Ethics committee at the University of Queensland. In all studies, participants ticked a box before starting the survey, indicating their informed consent.

### Method

**Participants.** Participants were 180 international students at a large Australian university who had only been in Australia for one month (54 males, 124 females, 2 did not indicate their gender). Participants had a mean age of 22.0 years ( $SD = 4.00$ ) and were born in Asia (i.e., China, Hong Kong, Indonesia, Malaysia, and Singapore).

**Measures.** Participants completed a survey that included demographic questions, and scales measuring multiple group membership and wellbeing (i.e., life satisfaction, depression, anxiety, stress).

**Multiple group membership.** Multiple group membership was assessed with four items from the Exeter Identity Transition Scale (EXITS; see Haslam et al., 2008). These included “I belong to a lot of groups”, “I join in the activities of lots of different groups”, “I have friends who are members of lots of groups”, and “I have strong ties with lots of different groups”. Each item was rated on a 7-point scale (1=*Strongly Disagree*, 7=*Strongly Agree*;  $\alpha = .91$ ).

**Satisfaction With Life Scale.** (SWLS; Diener, Emmons, Larsen, & Griffin, 1985). Five items (e.g., “I am satisfied with my life”) assessed one’s judgment of satisfaction with one’s life ( $\alpha = .87$ ). Each item was rated on a 7-point scale (1=*Strongly disagree*, 7=*Strongly agree*).

**Depression Anxiety Stress Scales.** (DASS-21; Lovibond & Lovibond, 1995). Depression, anxiety, and stress were measured using the DASS-21. The DASS-21 consists of three 7-item subscales that measure depression (e.g., I felt down-hearted and blue;  $\alpha = .88$ ), anxiety (e.g., I felt I was close to panic;  $\alpha = .80$ ), and stress (e.g., I found it hard to wind down;  $\alpha = .85$ ). It has excellent reliability and validity in both clinical and non-clinical samples (Crawford et al., 2009; Henry & Crawford, 2005). Participants were asked to indicate how much the items had applied to them during the past week on a scale ranging

from 0=Did not apply to me at all, to 3=Applied to me very much, or most of the time. For each subscale, responses were summed and multiplied by two in accordance with recommended practice (Lovibond & Lovibond, 1995).

### Results and Discussion

Descriptive statistics and bivariate correlations of key variables are presented in Table 1. Multiple group membership was not significantly related to life satisfaction ( $r = .121, p = .105$ ), depression ( $r = -.104, p = .167$ ), anxiety ( $r = -.105, p = .162$ ), or stress ( $r = -.070, p = .350$ ), suggesting that belonging to multiple groups may not be associated with enhanced wellbeing for Asian participants.

This finding contrasts with mounting evidence of the wellbeing benefits of multiple group memberships (Jetten et al., 2012; Jetten et al., 2014), and provides initial support for our argument that Asians may derive fewer wellbeing benefits from multiple groups relative to Westerners. However, aside from the fact that one should be careful in drawing inferences from an absence of a significant relationship (i.e., confirming the null hypothesis), another limitation is that having only explored this relationship in Asians, questions about (a) the extent to which the multiple group membership effect differs across cultures, and (b) the mechanism underlying this cultural difference (if any), remain. We address these limitations in the following studies.

Table 1  
*Descriptive Statistics and Correlations. Study 1; N = 180.*

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5
1. Multiple group membership	3.43	1.29	--	.12	-.10	-.11	-.07
2. Wellbeing: Life satisfaction	4.88	1.17		--	-.36**	-.36**	-.34**
3. Wellbeing: Depression	8.94	8.32			--	.74**	.78**
4. Wellbeing: Anxiety	11.68	8.14				--	.82**
5. Wellbeing: Stress	12.43	8.53					--

\*  $p < .05$ , \*\*  $p < .01$



## Study 2

Study 2 directly compared Western and Asian samples to investigate cultural differences in the relative benefit to psychological wellbeing of belonging to multiple groups. Our prediction was that culture would moderate the positive effect of multiple group memberships on wellbeing. Specifically, belonging to multiple groups would benefit the wellbeing of Asians to a lesser extent than Westerners. A second goal of Study 2 was to examine a potential mechanism underlying this cultural difference — the notion that Asians are less likely to derive support resources from their multiple group memberships (Kim et al., 2006; Sherman et al., 2009; Taylor et al., 2004). We predicted that only for Western participants, social support would mediate the effect of multiple group memberships on psychological wellbeing. We expected that this mediational path would not be significant for Asian participants. In our examination of these predictions, we adopted happiness and depression as indicators of wellbeing.

### Method

**Participants.** Participants were 137 undergraduate students at a large Australian university; 60 international students who were born and raised in Asia and described their ethnicity as Chinese (17 males and 43 females), and 77 Australians Caucasians (28 males and 49 females). Participants either received course credit or 10 Australian dollars for their participation. Asian participants ( $n = 60$ ) were on average 23.2 years old ( $SD = 4.01$ ) and the average length of time spent in Australia was 23.73 months. Western participants ( $n = 77$ ) had a mean age of 19.6 years ( $SD = 3.69$ ).

**Measures.** Participants completed a survey that included demographic questions, and scales measuring multiple group membership, social support, and wellbeing.

**Multiple group membership.** An abbreviated two item scale (i.e., “I am a member of lots of different social groups” and “I have friends who are in lots of different social groups”), assessed the extent to which individuals belong to multiple groups (Jetten, Haslam, Pugliese, Tonks, & Haslam, 2010;  $r = .68$ ). These items have been used in previous research and have been found to demonstrate good internal reliability (see Jetten et al., 2010). Each item was rated on a 7-point scale (1=*Strongly Disagree*, 7=*Strongly Agree*).

**Social support.** Participants’ level of social support was measured using four items adapted from Van Dick and Haslam (2012; e.g., “Do you get the help you need from other people?”;  $\alpha = .94$ ), to which participants responded using a 7-point scale (1=*Not at All*, 7=*Completely*).

**Wellbeing.** Two measures indexed this construct. A single item of overall wellbeing, indexing happiness, was used. Previous research has argued that single-item measures of happiness are not only valid but also, produce similar findings to multi-item scales of this construct (see Abdel-Khalek, 2006; Jetten et al., 2012). Participants were asked to respond to the item “Presently would you describe yourself as:” using a 5-point scale from 1 “*Very unhappy,*” to 5, “*Very happy.*”

The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) comprising 20 items (e.g., “I was bothered by things that usually don’t bother me”) assessed levels of depression ( $\alpha = .91$ ). Each item was rated on a 4-point scale (0=*Rarely or none of the time,* to 3=*Most or all of the time*).

## Results

Descriptive statistics for the sample by culture are provided in Table 2. While multiple group membership was not associated with happiness ( $r = -.058, p = .657$ ) in Asian participants, it was associated with greater levels of happiness ( $r = .343, p = .002$ ) in Western participants. The difference between these correlations was statistically significant,  $Z = -2.36, p = .018$ .

Results also revealed that whereas multiple group membership was not associated with depression ( $r = .063, p = .632$ ) in Asian participants, belonging to multiple groups was associated with lower levels of depression ( $r = -.317, p = .005$ ) in Western participants. The difference between these correlations was also statistically significant,  $Z = 2.22, p = .026$ .

Table 2  
*Descriptive Statistics as a Function of Culture. Study 2; N = 137.*

Variable	Western Participants		Asian Participants	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1. Multiple group membership	5.25	1.45	4.84	1.35
2. Wellbeing: Happiness	4.12	0.93	3.50	0.91
3. Wellbeing: Depression	0.76	0.52	0.87	0.45
4. Social support	5.68	1.25	5.28	1.02

**Culture moderates the positive effect of multiple group membership on wellbeing.**

A moderation analysis (Hayes, 2013, model 1; significance levels were calculated using unstandardized values in Hayes PROCESS model 1, as recommended by Hayes & Preacher, (2014)) was conducted to examine the influence of culture as a moderator of the relationship between multiple group membership and happiness. Multiple group membership was included as a continuous predictor, with happiness as the outcome variable. Culture (Asian versus Western) was entered as the moderator. Results showed that culture,  $B = 0.29$ , 95% CI [.131, .456],  $t = 3.57$ ,  $p < .001$ , but not multiple group membership,  $B = 0.11$ , 95% CI [-.019, .233],  $t = 1.67$ ,  $p = .097$ , significantly predicted happiness. The interaction between culture and multiple group membership was significant,  $B = 0.13$ , 95% CI [.006, .254],  $t = 2.07$ ,  $p = .041$ . Simple slopes analysis revealed that multiple group membership was associated with higher levels of happiness for Western participants,  $B = 0.22$ , 95% CI [.041, .400],  $t = 2.42$ ,  $p = .017$ , but not for Asian participants,  $B = -0.04$ , 95% CI [-.211, .132],  $t = -0.45$ ,  $p = .650$  (see Figure 2).

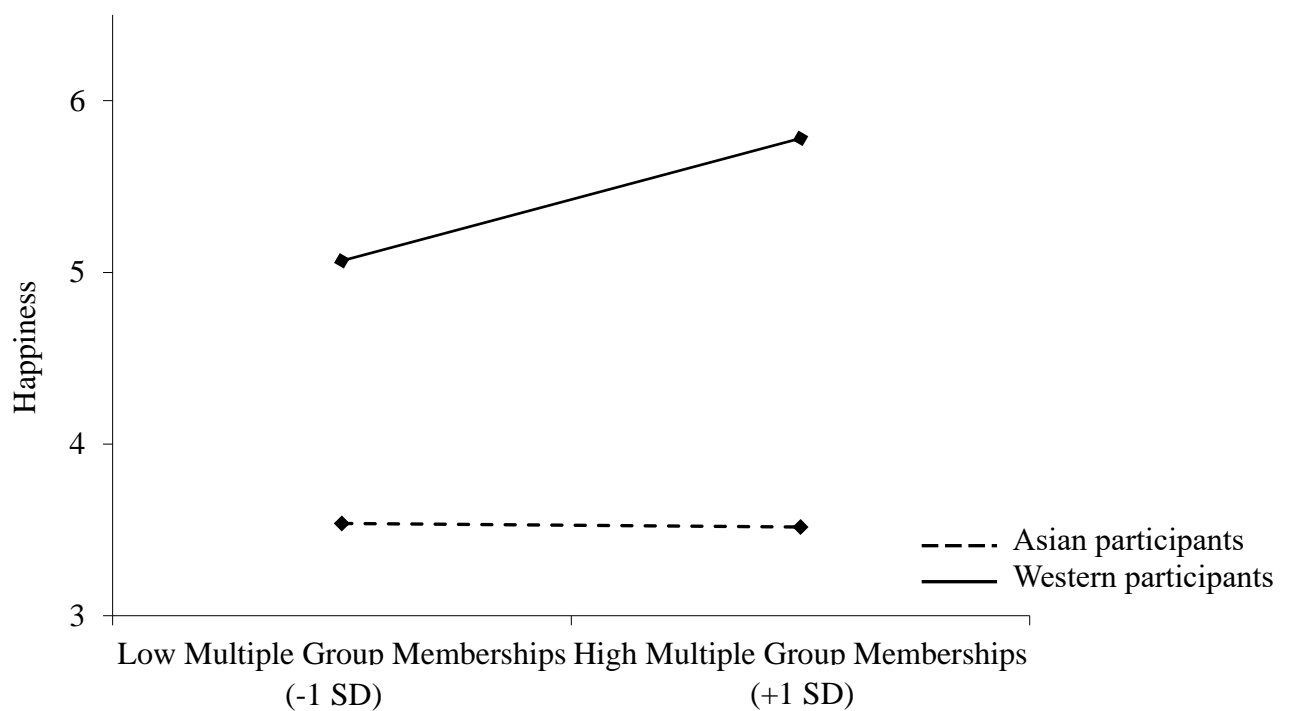


Figure 2. Happiness ratings as a function of multiple group membership and culture in Study 2;  $N = 137$ .

A second moderation analysis was conducted to examine the influence of culture as a moderator of the relationship between multiple group membership and depression. Analysis revealed no significant effect of culture,  $B = -0.04$ , 95% CI [-.128, .042],  $t = -1.01$ ,  $p = .314$ , or multiple group membership,  $B = -0.06$ , 95% CI [-.122, .012],  $t = -1.62$ ,  $p = .107$ , on depression. However, the interaction between culture and multiple group membership was significant,  $B = -0.07$ , 95% CI [-.135, -.0008],  $t = -2.00$ ,  $p = .047^1$ . Simple slopes analysis revealed that multiple group membership was associated with lower levels of depression for Western participants,  $B = -0.11$ , 95% CI [-.208, -.021],  $t = -2.42$ ,  $p = .017$ , but not for Asian participants,  $B = 0.02$ , 95% CI [-.075, .117],  $t = 0.43$ ,  $p = .665$  (see Figure 3).

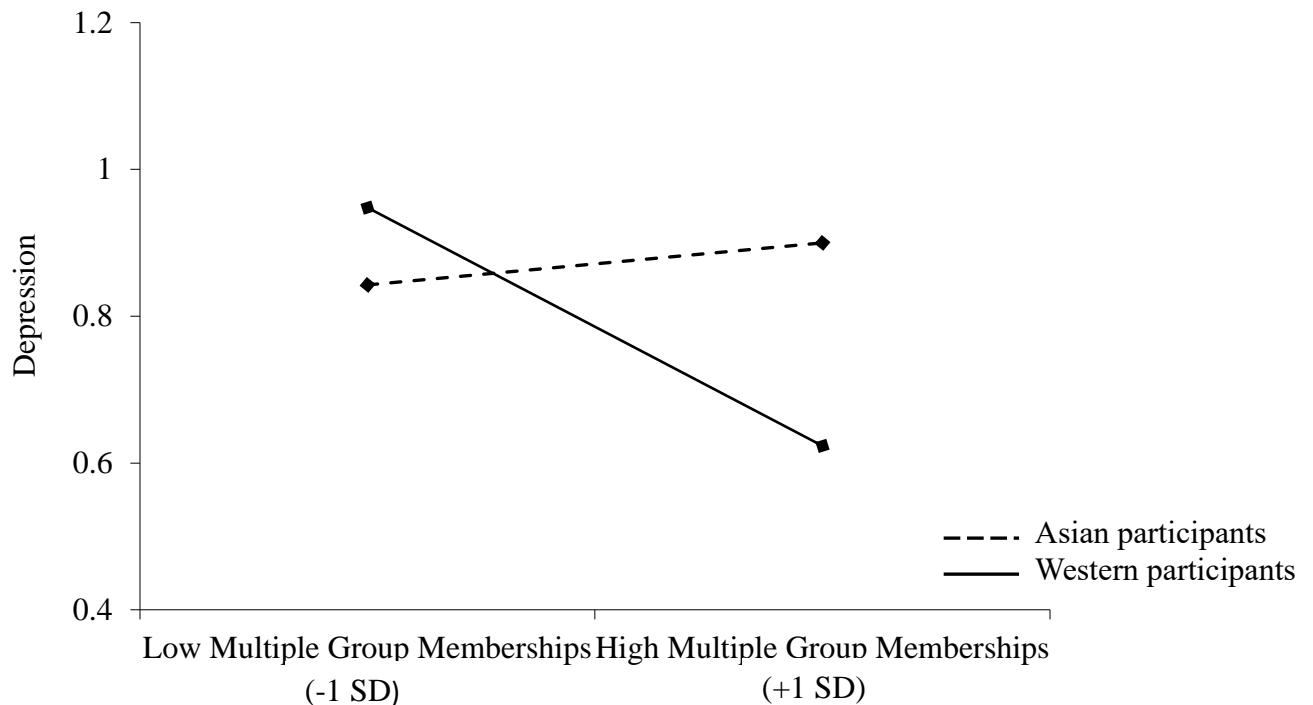
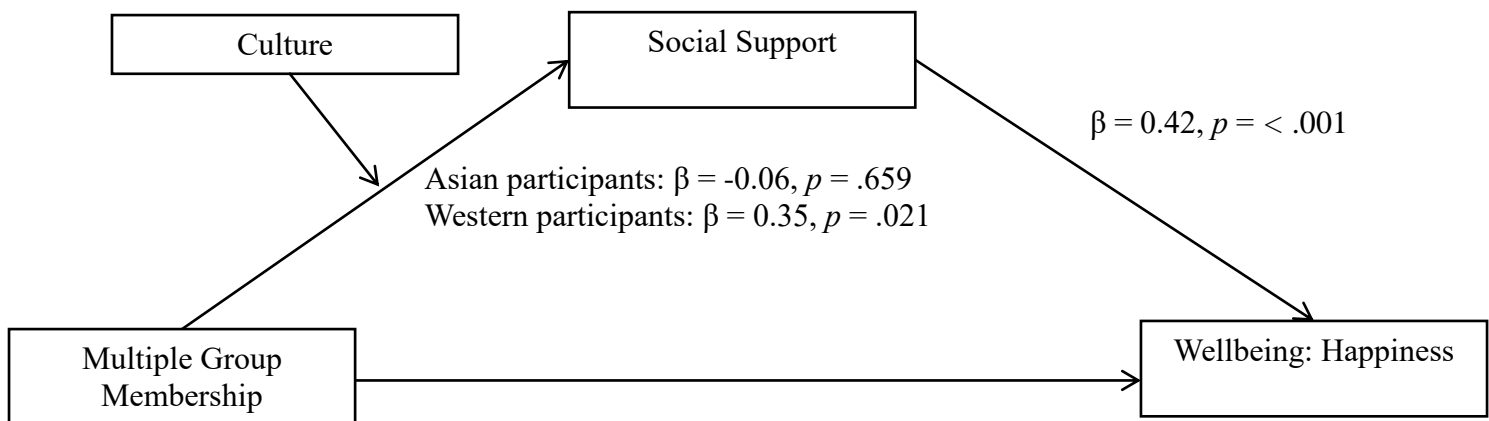


Figure 3. Depression ratings as a function of multiple group membership and culture in Study 2;  $N = 137$ .

**Social support mediates the positive effect of multiple group membership on wellbeing for Western, but not Asian, participants.** To test whether the positive effect of multiple group membership on happiness could be explained by a difference between cultural groups in the mediating role of social support, a moderated mediation analysis with 10,000 bootstrap samples was conducted (Hayes, 2013, model 8; significance levels were calculated using unstandardized values in Hayes PROCESS model 8, as recommended by Hayes & Preacher (2014)). Multiple group membership was included as a continuous predictor, with

happiness as the outcome variable. Social support was entered as a continuous mediator, and culture (Asian versus Western) was entered as the moderator. Analysis revealed no significant effect of multiple group membership,  $B = 0.14$ , 95% CI [-.031, .307],  $t = 1.61$ ,  $p = .109$ , or culture,  $B = 0.18$ , 95% CI [-.013, .374],  $t = 1.85$ ,  $p = .067$ , on social support. However, the interaction between multiple group membership and culture on social support was significant,  $B = 0.17$ , 95% CI [.002, .335],  $t = 2.00$ ,  $p = .048$ . Conditional indirect effects (IE) revealed a significant indirect effect of multiple group membership on happiness via social support for Western participants, IE = 0.10, standard error [SE] = 0.05, 95% CI [.026, .205], but not for Asian participants, IE = -0.02, standard error [SE] = 0.04, 95% CI [-.107, .059]. Results showed that the indirect effect through social support was significantly different between Asian and Western participants,  $B = 0.12$ , 95% CI [.017, .267]. The direct effect of the interaction between multiple group membership and culture on happiness was not significant with the mediator in the model,  $B = 0.07$ , 95% CI [-.032, .170],  $t = 1.35$ ,  $p = .181$  (see Figure 4). This is consistent with our prediction that it is the capacity of multiple group memberships to provide support that is moderated by culture.



*Figure 4.* The relationship between multiple group membership and happiness is mediated through social support, but only among Western participants. Study 2;  $N = 137$ .

Notes: Standardized beta values are reported in the figure to aid interpretability, however, unstandardized coefficients were used to assess significance (as reported in the text), in accordance with recommendation (Hayes & Preacher, 2014).

To examine whether social support would mediate the effect of multiple group membership on depression for Western, but not Asian, participants, a second moderated mediation analysis with 10,000 bootstrap samples was conducted (Hayes, 2013, model 8).

The interaction between multiple group membership and culture on social support was significant,  $B = 0.17$ , 95% CI [.002, .335],  $t = 2.00$ ,  $p = .048$ . Conditional indirect effects (IE) revealed a significant indirect effect of multiple group membership on depression via social support for Western participants, IE = -0.05, standard error [SE] = 0.02, 95% CI [-.104, -.013], but not for Asian participants, IE = 0.01, standard error [SE] = 0.02, 95% CI [-.029, .055]. Results showed that the indirect effect through social support was significantly different between Asian and Western participants,  $B = -0.06$ , 95% CI [-.136, -.008]. The direct effect of the interaction between multiple group membership and culture on depression was not significant with the mediator in the model,  $B = -0.04$ , 95% CI [-.094, .020],  $t = -1.28$ ,  $p = .202$  (see Figure 5).

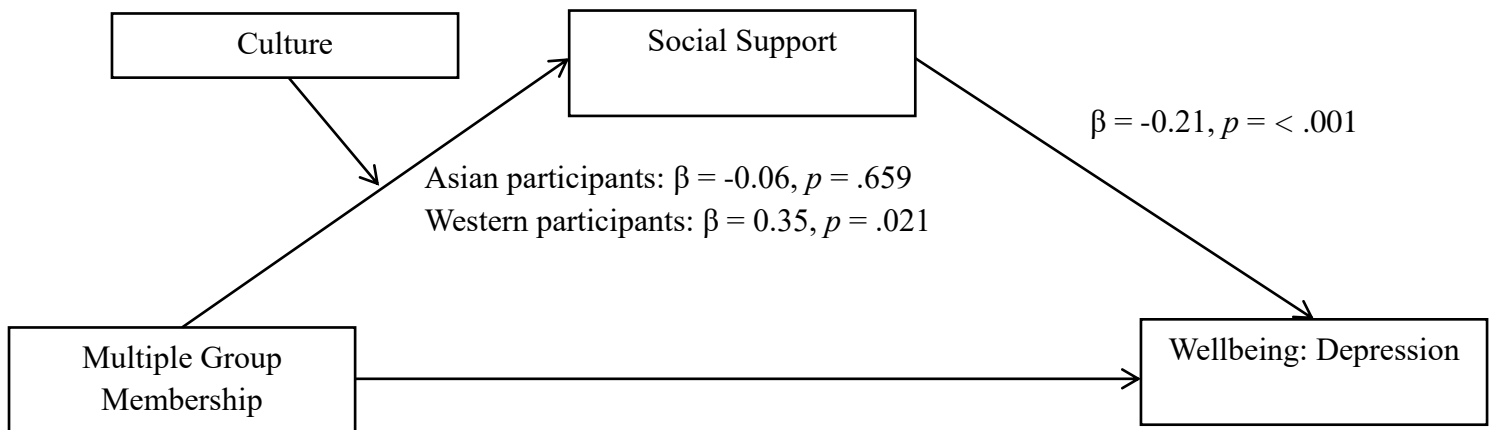


Figure 5. The relationship between multiple group membership and depression is mediated through social support, but only among Western participants. Study 2;  $N = 137$ .

We also tested the most plausible alternative mediation model, which was that individuals with better wellbeing would be more likely to engage in drawing social support from different social groups, and thus, more likely to feel a part of multiple groups (Hayes, 2013, model 4). Happiness was included as a continuous predictor, with multiple group membership as the outcome variable. Social support was entered as a continuous mediator. However, this model was not consistent with the data. In the Western subsample, both the indirect effects (IE) of happiness, IE = 0.19, standard error [SE] = 0.16, 95% CI [-.070, .562], and depression, IE = -0.34, standard error [SE] = 0.22, 95% CI [-.855, .035], on multiple group membership were not significant. Similarly, in the Asian subsample, both the indirect effects of happiness and depression on multiple group membership were not significant.

## **Discussion**

In Study 2, we found that belonging to multiple groups was associated with greater levels of psychological wellbeing for Western participants, but not for Asian participants, and this was true across two indexes of wellbeing: happiness and depression. More specifically, we found that only for Western participants, the impact of belonging to multiple groups on wellbeing was fully mediated by social support.

It thus appears that there are boundary conditions for the effect of multiple group memberships on wellbeing. Even though multiple group memberships serve as a psychological resource from which individuals can receive and benefit from the support provided by fellow group members to enhance wellbeing (Haslam, 2004; Jetten et al., 2012; Jetten et al., 2014), for Asian participants, we observed that they were not deriving as much support from their group memberships, reducing the positive effect of multiple group membership on wellbeing. We propose that this lack of social support from multiple group memberships arises from Asian cultural norms about relationships and support seeking in which there is a reluctance to seek support because one should not burden their social networks (Kim et al., 2006; Kim et al., 2008; Taylor et al., 2004). We test this prediction in Study 3 by including measures indexing concerns about burdening others.

A potential limitation of Studies 1 and 2 is that the studies' samples comprised Asian international students who find themselves in a unique situation. They might belong to many different groups in their home countries (e.g., family, friendship, community, recreational groups), but experience difficulty in utilizing them for support resources and deriving associated wellbeing benefits because they are not easily accessible (i.e., located overseas in their home countries). Also, the group memberships to which Asian international students belong in Australia may be quite different from those of Australians. That is, the new group memberships may be weaker, less stable or less meaningful given they have only been part of them for a shorter duration; possibly limiting the extent to which support resources can be derived from these memberships. This may explain why Asians may derive fewer wellbeing benefits from multiple groups relative to Westerners in our studies. We address this limitation in Study 3.

### **Study 3**

In Study 3, we measured perceived burden as a proxy to assess one's reluctance to draw upon relationships for support resources. In line with the above reasoning, we tested whether the effect of multiple group memberships on wellbeing was dependent on the extent to which one is reluctant to seek social support from their relationships. Specifically, we

expected that multiple group memberships would only be associated with enhanced psychological wellbeing for those Asian participants who were least reluctant to draw on support from others. Importantly, Study 3 also addressed a limitation of Studies 1 and 2 by investigating this prediction in a sample of Asian students at a university in Singapore residing within their cultural context.

## Method

**Participants.** Participants were 105 students at a Singapore university (43 males and 62 females). Participants received 6 Singapore dollars for their participation. On average, participants were 21.4 years old ( $SD = 1.54$ ) and all described their ethnicity as Chinese.

**Measures.** Participants completed a survey that included demographic questions, the multiple group membership scale (see Study 2; Jetten et al., 2010;  $r = .59$ ), and the Satisfaction with Life Scale (see Study 1; Diener et al., 1985;  $\alpha = .85$ ).

**Reluctance to enlist social support.** Three items were developed to measure the extent to which one is reluctant to enlist social support from relationships due to concerns about burdening others (i.e., “It is important for me not to burden others with my problems”; “One should avoid troubling others”, and “I make an effort not to impose on others”;  $\alpha = .80$ ). Each item was rated on a 7-point scale (1=*Strongly disagree*, 7=*Strongly agree*).

## Results and Discussion

Table 3 provides descriptive statistics and results of bivariate correlations between key variables. Multiple group membership ( $M = 5.14$ ,  $SD = 1.07$ ) was not significantly related to life satisfaction ( $M = 4.57$ ,  $SD = 1.12$ ),  $r = .130$ ,  $p = .186$ .

A moderation analysis (Hayes, 2013, model 1; significance levels were calculated using unstandardized values) was used to examine whether the degree of reluctance to enlist social support would moderate the relationship between multiple group membership and life satisfaction. Multiple group membership was included as a continuous predictor, and life satisfaction as the outcome variable. Reluctance to enlist social support was entered as a continuous moderator. There was no significant effect of multiple group membership,  $B = 0.13$ , 95% CI [-.072, .332],  $t = 1.28$ ,  $p = .205$ , or reluctance to enlist support,  $B = 0.02$ , 95% CI [-.208, .252],  $t = 0.19$ ,  $p = .850$ , on life satisfaction. Consistent with our prediction, the interaction term between belonging to multiple groups and reluctance to enlist support was significant,  $B = -0.18$ , 95% CI [-.352, -.010],  $t = -2.10$ ,  $p = .038$ . Simple slopes analysis revealed that belonging to multiple groups was associated with greater levels of life satisfaction for those who were least reluctant to enlist social support,  $B = 0.32$ , 95% CI



[.034, .597],  $t = 2.22$ ,  $p = .029$ , but was unrelated to life satisfaction for participants who were more reluctant to enlist social support,  $B = -0.06$ , 95% CI [-.308, .197],  $t = -0.44$ ,  $p = .663$  (see Figure 6).

Table 3  
*Descriptive Statistics and Correlations. Study 3; N = 105.*

Variable	<i>M</i>	<i>SD</i>	1	2	3
1. Multiple group membership	5.14	1.07	--	.17	.13
2. Reluctance to enlist support	5.23	1.03		--	.04
3. Wellbeing: Life satisfaction	4.56	1.12			--

\*  $p < .05$ , \*\*  $p < .01$

Here, we replicate the findings from previous studies that multiple group memberships are not associated with psychological wellbeing for Asian participants. However, additionally, we found that one's reluctance to enlist social support moderated the relationship between multiple group membership and psychological wellbeing, highlighting that belonging to multiple groups was in fact, associated with greater wellbeing among those Asian participants who were less reluctant to enlist social support. As the findings from our moderation analysis suggest, belonging to multiple groups may benefit the wellbeing of Asians to a lesser extent, especially when they are more sensitive to concerns about burdening others. This potentially increases their reluctance to draw on support resources from their relationships, reducing the positive effect of multiple group memberships on wellbeing.

Taken together, the findings across the three studies show that for Asians, multiple group membership is not strongly associated with psychological wellbeing, with correlations ranging between .058 and .130 across three studies and five indicators of wellbeing. This suggests that for Asians, the relationship between multiple group membership and wellbeing is weaker than it is for Westerners. To further interrogate this point, we conducted an

empirical review of the work assessing the relationship between multiple group memberships and wellbeing.

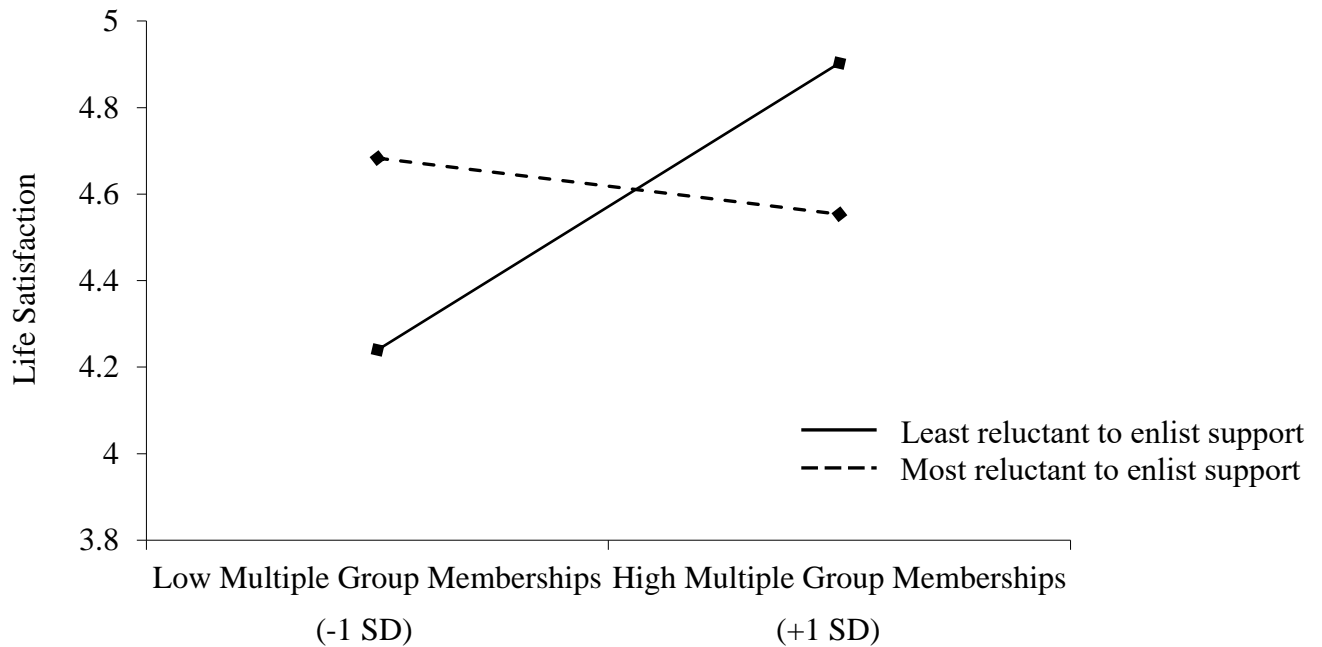


Figure 6. Life satisfaction ratings as a function of multiple group membership and one's reluctance to enlist social support. Study 3;  $N = 105$ .

#### Study 4

Study 4 aimed to (1) investigate the robustness of the effect of multiple group memberships on wellbeing in the literature (both the Asian and Western cultural contexts), and (2) determine whether this effect is smaller in Asian, compared to Western, cultural contexts. Addressing these aims, we obtained effect sizes by identifying and integrating relevant studies in the literature examining the relationship between multiple group memberships and psychological wellbeing. PsycINFO and PubMed were searched for relevant studies using the following keywords: *multiple group membership*, *social group memberships*, and *greater number of group identification*. Eligible studies were published between 1990 to August 2015, in English and in a peer-reviewed journal, and included quantitative measures or manipulations of number of group memberships across different life domains (e.g., leisure or social group, community group, family) along with a dependent quantitative measure of psychological wellbeing (i.e., life satisfaction, happiness, self-esteem, psychological distress, mood, depression, anxiety, and stress).

The search produced a total of 735 references in PsycINFO and 1030 references in PubMed, of which 1564 were unique references. Of these, we identified 15 relevant articles reporting 23 different studies, with a total of 14,063 participants. None of these studies compared Westerners with Asians, and only 4 were conducted with Asian participants. More detail on each of the studies is provided in Table 4. In addition to these studies, we included our data sets from Study 1 to Study 3 in the integrative analysis. This resulted in 27 independent studies for the analysis.

### **Results and Discussion**

The meta-analytical procedure reported in Borenstein, Hedges, Higgins, and Rothstein (2009) was used to determine the overall relationship between multiple group memberships and wellbeing. From the studies identified, 27 effect sizes were calculated with a total sample size of 14,063 participants and correlations ranging from -0.06 to 0.48. A random effects model (which assumes that the true effect size varies across studies and follows a normal distribution around the mean) revealed an overall mean effect size of  $r = 0.22$ , 95% CI [.175, .267],  $Z = 9.13$ ,  $p < .001$ .

To compare the effect size of studies consisting primarily of Westerners to studies involving Asians, subgroup analyses were conducted. For the studies with Asian participants ( $k = 7$ ), 7 effect sizes were calculated with a total of 1153 participants and correlations varying between -0.06 and 0.26. The random effects model revealed a mean effect size of  $r = 0.13$ , 95% CI [.072, .187],  $Z = 4.38$ ,  $p < .001$ , indicating that the effect size was small (Cohen, 1988). For the studies with Western participants ( $k = 20$ ), 20 effect sizes were calculated with a total sample size of 12,910 participants and correlations ranging between 0.08 to 0.48. A random effects model showed a mean effect size of  $r = 0.25$ , 95% CI [.194, .302],  $Z = 8.67$ ,  $p < .001$ , for these studies. More specifically, in 95% of all possible meta-analyses, the true mean effect would probably fall in the range of .194 to .302 for Westerners, indicating a robust effect. In contrast, for Asians, the true mean effect would usually fall in the range of .072 to .187, suggesting there is a higher probability that the true effect is weaker for Asians, and likely to be null in some analyses (Cohen, 1988). As it is predicted that multiple group membership processes would be different across cultures, in calculating the  $Q$ -value, the between-studies variance,  $T_2$ , was computed within subgroups and used as a separate estimate for each subgroup. The  $Q$ -value for the difference was 8.75 with 1  $df$  and  $p = .003$ .

The present analysis is the first review applying meta-analytic techniques to interrogate the relationship between multiple group memberships and indices of wellbeing. We found some evidence that multiple group membership was more strongly related to

wellbeing in the studies involving Westerners than in studies involving Asians. This strengthens our argument that individuals in cultural contexts that privilege drawing support from their relationships may reap greater wellbeing benefits from their multiple group memberships.

Nevertheless, some caution is warranted in interpreting the results of this review. The purpose of this review was not to provide an all-encompassing meta-analysis, but rather an initial interrogation of the existing literature applying meta-analytic principles. A potential limitation is the small number of studies included in the Asian subgroup analysis. Of note, Studies 1 to 3 contributed 3 out of the 7 studies in this analysis, and whilst these all had confidence intervals including 0, the other 4 studies did not. The reason for this is not clear, but publication bias against null effects may play a role (Franco, Malhotra, & Simonovits, 2014). If so, the mean effect size for Asians in reality may be even weaker, relative to Westerners. Despite this, our findings suggest that compared to Westerners, Asians may generally derive fewer wellbeing benefits from belonging to multiple groups.

### **General Discussion**

In this current research, we apply a novel theoretical framework to understand some important cross-cultural differences in the relationship between multiple group memberships and psychological wellbeing. Overall, we found support for our argument that, belonging to multiple groups may confer little, or fewer, wellbeing benefits for Asians relative to Westerners. Importantly, our findings provide further evidence for a growing body of research claiming that multiple group memberships can form the basis of a ‘social cure’; the sense of shared social identities derived from belonging to multiple groups are an important basis for social support, which is a critical social factor in protecting wellbeing (Haslam et al., 2009; Jetten et al., 2012). Of note though, we provide some of the first evidence for the boundary conditions of this effect, showing that this relationship is more likely to be observed for individuals from Western than Asian cultural contexts.

For Asians, we found that multiple group membership was not significantly, or only weakly, associated with wellbeing. This was replicated across 3 survey studies in samples comprising Asian students from Australia and Singapore using multiple indices of wellbeing (Studies 1 to 3), and was also reflected in the findings of our review applying meta-analytic techniques (Study 4). In particular, in our cross-cultural study (Study 2) and review (Study 4), we showed that belonging to multiple groups was comparatively less beneficial to the psychological wellbeing of Asians, relative to Westerners. This leads us to conclude that cultural differences in the extent to which individuals derive wellbeing benefits from

belonging to multiple groups can exist. Specifically, whilst belonging to multiple groups is likely to confer wellbeing benefits for individuals from Western cultures, the ‘more the merrier’ effect may hold less truth for individuals from Asian cultures. As these findings suggest, it is important to consider an individual’s cultural context to obtain a full understanding of their psychology (Kim & Markus, 1999).

Critically though, in examining the cultural underpinnings of multiple group membership processes, the present analysis sheds new light on the contribution that cultural background makes to understanding how individuals derive psychological resources from their group memberships in different ways. Utilization of *social group resources* (e.g., support) is in fact interconnected with cultural norms about relationships. Specifically, it was found in Study 2, that social support mediated the effect of multiple group membership on wellbeing for Westerners but not Asians. Also, Study 3 showed that among Asians, multiple group membership was only associated with wellbeing for those who were least reluctant to enlist social support due to concerns about burdening others. Our current work therefore provides the first empirical demonstration that, compared to Westerners, Asians may reap fewer wellbeing benefits from belonging to multiple groups. This is possibly because of an emphasis on different cultural norms on relationships and support seeking across cultures (i.e., the extent to which it is perceived as appropriate to draw support resources from others), thereby leading support seeking to be perceived differently in different cultures (Kim et al., 2008). Among Asians, the cultural notion that it is important not to be a source of burden on others may cause them to worry about imposing on their relationships by requesting support (Kim et al., 2008) which, in turn, strengthens their reluctance to draw on such resources from their multiple group memberships resulting in reduced wellbeing benefits being derived from these memberships. Conversely, the present analysis suggests that individuals from Western cultures appear to have fewer concerns about deriving support from their social group memberships, which in turn is associated with enhanced wellbeing. In fact, these findings are in line with the literature showing cross-cultural differences in group processes, where it is argued that self-concepts and group behaviors are construed in more relational ways in Asian cultural contexts than in Western cultural contexts (Yuki & Takemura, 2013). In groups, Asians may be more focused on maintaining harmonious and reciprocal relationships, and therefore, they may be more reluctant to seek support from their group members in order to maintain these delicate interpersonal ties. By contrast, maintaining interpersonal ties and social harmony in groups may be less of a concern in Western cultural contexts. In this way, Westerners may feel more able to obtain support from their multiple group memberships.

Despite these cultural variations in notions about support seeking, it is noteworthy that Study 2 found social support to be associated with greater wellbeing for both Asians and Westerners. This finding is in line with an extensive body of research documenting the mental health benefits of social support (House et al., 1988; Thoits, 1995). What is interesting from the findings though, is that while Asian cultural norms about relationships and support seeking can make Asians more reluctant to enlist social support (Kim et al., 2006; Kim et al., 2008; Taylor et al., 2004), this does not appear to prevent them from perceiving such support as beneficial. Specifically, for Asians, the findings suggest that the costs involved in utilizing social support (e.g., highlighting one's incompetence; over-taxing the resources of others; Bolger, Zuckerman, & Kessler, 2000; Siedman et al., 2006) were more likely to occur *in the process* of deriving support from others, rather than *after* such support was provided. This is reflected in the non-significant relationship between multiple group membership and social support, but significant positive relationship between social support and wellbeing. In contrast, we did not find evidence of this "cost" in our sample of Westerners. Given that previous research has highlighted that Asians can benefit from seeking and receiving support from relationships that are perceived as mutual and interdependent (i.e., the individual had previously provided support to the relationship partner; Wang & Lau, 2015), future research could examine these processes in greater detail and explore whether Asians may possibly derive support resources from their mutual relationships when belonging to multiple groups, thereby reaping wellbeing benefits from multiple group memberships.

We note that the current studies were not without limitations. First, the cross-sectional nature of the data does not permit us to make causal inferences, and thus, directionality of effects cannot be inferred. However, it is worth noting that the alternative model that we tested in Study 2 did not provide a superior fit for the data. Also, because our study samples comprised only university students (Studies 1 to 3), the findings may not generalize to a non-university population or to clinical populations who may be more socially isolated. All these limitations should be addressed in future work by examining the generalizability of findings to other populations and by examining evidence for the predicted relationship longitudinally.

Another limitation is that our hypotheses in Studies 1 and 2 (i.e., weaker relationship between multiple group memberships and wellbeing for Asians, relative to Westerners) were examined using samples of Asian international students. Directly comparing Asian international students to Australian Caucasian students may have created a potential confound in Study 2 — that these Asian participants' unique situation may have influenced the ease and extent to which they derived support and gained wellbeing benefits from their

group memberships. The present data do not allow us to rule out this alternative explanation. However, our findings from Study 3 speak to this potential confound. In this study, we replicated the findings with a sample of Asian students in Singapore who were within the context of their home culture, and showed that multiple group membership was not associated with wellbeing. This finding, obtained in an un-confounded study context, substantiates our argument that Asians may generally derive fewer wellbeing benefits from belonging to multiple groups than Westerners. Nevertheless, it is recommended that future research explore and replicate these effects in other samples, for instance, (a) Asians who are within their cultural context or (b) Asian international students could be compared to Western international students (e.g., Europeans) in the Australian context.

Lastly, for practical reasons, social support was measured using four items adapted from Van Dick and Haslam (2012) instead of the much longer COPE Inventory (Carver, Scheier, & Kumari-Weintraub, 1989), a commonly used measure to assess cultural differences in social support seeking (Kim et al., 2006). This social support measure has in fact been shown to demonstrate high reliability in Western samples (Van Dick & Haslam, 2012), though it has not previously been used in Asian samples. Apart from this, the other measures used in our studies have previously been used in both Asian and Western samples with adequate psychometric properties. In general, nonetheless, it is recommended that future work should examine the hypotheses using other scales to extend as well as replicate our findings.

Overall, our findings are consistent with the literature demonstrating cross-cultural differences in group processes (e.g., variations across cultures in how individuals relate to groups; Yuki & Takemura, 2013). However, there are several possible interpretations of our findings. For instance, research has suggested that multiple group memberships lower one's wellbeing because groups can demand too much effort and deplete one's limited time and energy (Bolger, DeLongis, Kessler, & Wethington, 1989). In line with the strong motivation to maintain harmonious and reciprocal relationships, and relatedly, the strong emphasis on the fulfillment of role-based obligations in relationships in Asian cultural contexts (Rothbaum, Pott, Azuma, Miyake, & Weisz, 2000), it is therefore possible that Asians derive fewer wellbeing benefits from belonging to multiple groups because of their need to fulfill obligations (e.g., to reciprocate support). This explanation should be examined in future work, ideally with populations other than undergraduate students. In addition, future research could examine these cross-cultural differences in group processes in greater detail to understand how people conceptualize their multiple group memberships. This may help to shed light on

cultural differences in what constitutes multiple group memberships and what it means to belong to multiple groups.

Nevertheless, the current work has generated important insights about the function of multiple group membership processes in different cultural contexts. More specifically, it has provided the first empirical evidence on the circumstances in which these group memberships can sometimes fail to have any positive effects on wellbeing. This has important practical implications for psychosocial interventions involving attempts to enhance wellbeing by 1) advocating the building and development of social group memberships or 2) facilitating individuals to draw support resources from their group memberships (Jetten et al., 2014; Newlin, Webber, Morris, & Howarth, 2015). Our findings suggest that it may be important to tailor these interventions to the needs of Asians. For instance, when working with Asian clients, therapists may need to work with clients' reluctance to draw upon support resources from their relationships and help them tap these resources in a way that is consistent with Asian culture normative standards.

### **Conclusion**

Although the relationship between multiple group memberships and psychological wellbeing appears to be relatively well-established, our findings indicate that there is cross-cultural variation in this association. The wellbeing benefits from multiple group memberships are not only determined by how much support can be derived from belonging to multiple groups, but also how easy it is for an individual to draw upon these resources. Given that Asian cultural norms prescribe individuals not to draw on such support lightly, unfortunately, Asians may not fully benefit from the psychological resources their group memberships encompass.



Table 4. *The Relationship between Multiple Group Memberships and Psychological Wellbeing, as Reported in 27 Studies.*

Asians										
No.	Authors	Year	Journal	Study	N	Population	Multiple group membership measure	Psychological wellbeing measure	Overall wellbeing effect size ( <i>r</i> )	Country
1	Chang, Jetten, Cruwys, Haslam, & Praharso	2016		1	180	Students	4-item Exeter Identity Transition Scales (Haslam et al., 2008)	Satisfaction with Life Scale (Diener et al., 1985) & DASS-21 (Lovibond & Lovibond, 1995)	+0.10	International students born in Asia
2		2016		2	60	Students	2-item scale (Jetten et al., 2010)	1-item happiness scale & CES-D (Radloff, 1977)	-0.06	International students born in Asia
3		2016		3	105	Students	2-item scale (Jetten et al., 2010)	Satisfaction with Life Scale (Diener et al., 1985)	+0.13	Singapore
4	Ganga, Kutty, & Thomas	2014	Mental Health Review Journal		453	Young adults	Membership in clubs and organizations	The Achutha Menon Centre Positive Mental Health Scale (Ganga & Kutty, 2012)	+0.10 <sup>a</sup>	India
5	Jetten et al.	2015	PLoS One	1b	109	Retired older adults	3-item Exeter Identity Transition Scales (Haslam et al., 2008)	1-item personal self-esteem adapted from the Quality of Life Questionnaire (Logsdon, Gibbons, McCurry, & Teri, 2002)	+0.23	China
6				3a	154	Students	4-item scale	3-item personal identity strength adapted from Baray, Postmes, and Jetten (2009)	+0.19	China

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7	Takahashi, Thuy, Poudel, Sakisaka, Jimba, & Yasuoka	2011	BMC Public Health	92	Individuals with musculoskeletal impairments	Adapted Social Capital Assessment Tool (Harpham, De Silva, Jones, & Garlick, 2006)	Satisfaction with Life Scale (Diener et al., 1985)	+0.26 <sup>a</sup>	Vietnam
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Westerners										
No.	Authors	Year	Journal	Study	N	Population	Multiple group membership measure	Psychological wellbeing measure	Overall wellbeing effect size ( <i>r</i> )	Country
8	Brook, Garcia, & Fleming	2008	Personality and Social Psychology Bulletin		372	Students	Getting participants to list all of their important identities (i.e., group memberships and social roles)	CES-D (Radloff, 1977), anxiety subscale (Bradley & Lewis, 1990), wellbeing subscale (Bradley & Lewis, 1990), & Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983)	+0.08	United States - 66.7% White, 12.9 % Asian American, & 8.1% African American
9	Chang, Jetten, Cruwys, Haslam, & Praharso	2016		2	77	Students	2-item scale (Jetten et al., 2010)	1-item happiness scale & CES-D (Radloff, 1977)	+0.33	Australia
10	Cruwys, South, Greenaway, & Haslam	2015	Social Psychological and Personality Science	1	139	Students	7-item Exeter Identity Transition Scales (Haslam et al., 2008)	CES-D (Radloff, 1977)	+0.28	Australia
11				2	88	Students	Experimental manipulation of social identity salience by getting individuals to reflect on no groups, one group, or three groups	The Positive and Negative Affect Scale (Watson, Clark, & Tellegen, 1988)	+0.24	Australia
12	Haslam, Holme, Haslam, Iyer, Jetten, & Williams	2008	Neuropsychological Rehabilitation		53	Recovering stroke patients	12-item Exeter Identity Transition Scales (Haslam et al., 2008)	Life satisfaction scale (Haslam et al., 2005) & Chronic stress scale (Haslam & Reicher, 2006)	+0.21	United Kingdom
13	Haslam, Jetten, Haslam, Pugliese, & Tonks	2011	British Journal of Psychology		32	Older adults	3-item Exeter Identity Transition Scales (Haslam et al., 2008)	5-item personal identity strength scale (Jetten et al., 2010)	+0.44 <sup>a</sup>	United Kingdom

No.	Authors	Year	Journal	Study	N	Population	Multiple group membership measure	Psychological wellbeing measure	Overall wellbeing effect size ( <i>r</i> )	Country
14	Iyer, Jetten, Tsivrikos, Postmes, & Haslam	2009	British Journal of Social Psychology		100	Students	6-item Exeter Identity Transition Scales (Haslam et al., 2008)	8-item wellbeing scale (Branscombe, Schmitt, & Harvey, 1999)	+0.08	United Kingdom
15	Jetten at al.	2015	PLoS One	1a	29	Children	3-item Exeter Identity Transition Scales (Haslam et al., 2008)	7-item self-esteem scale adapted from Rosenberg (1965)	+0.48	United Kingdom
16				2	813	Adolescents	3-item Exeter Identity Transition Scales (Haslam et al., 2008)	1-item self-esteem scale (Robins, Hendin, & Trzesniewski, 2001)	+0.29	Australia
17				3b	78	Students	3-item Exeter Identity Transition Scales (Haslam et al., 2008)	1-item self-esteem scale (Robins et al., 2001)	+0.42	Australia
18				4	302	Students	By determining how many of the three identities (i.e., gender, university sports team fan, nationality) participants rate as being of more than median-level importance	Rosenberg Personal Self-esteem scale (Rosenberg, 1965)	+0.25	United States
19				5	148	Students	By assessing the extent to which participants rate the importance of seven identities as higher than the median	Rosenberg Personal Self-esteem scale (Rosenberg, 1965)	+0.20	United States

No.	Authors	Year	Journal	Study	N	Population	Multiple group membership measure	Psychological wellbeing measure	Overall wellbeing effect size ( <i>r</i> )	Country
20	Jetten, Haslam, & Barlow	2013	Social Psychological and Personality Science		816	Students	2-item Exeter Identity Transition Scales (Haslam et al., 2008)	Satisfaction with Life Scale (Diener et al., 1985)	+0.23	United Kingdom
21	Johnstone, Jetten, Dingle, Parsell, & Walter.	2015	Frontier of Psychology		76	Individuals residing in homelessness accommodation services	2-item scale (Jetten et al., 2010) & 4-item Exeter Identity Transition Scales (Haslam et al., 2008)	Personal Wellbeing Index by the International Wellbeing Group (2006)	+0.39	Australia
22	Jones, Williams, Jetten, Haslam, Harris, & Gleibs	2012	British Journal of Health Psychology		93	Patients with orthopaedic injuries or acquired brain injuries	12-item Exeter Identity Transition Scales (Haslam et al., 2008)	General Health Questionnaire (Goldberg, 1992)	+0.14	United Kingdom
23	Murray, Judd, Jackson, Fraser, Komiti, Pattison, Wearing, & Robins	2007	Social psychiatry and Psychiatric Epidemiology		394	Adults	Total number of groups to which participants belong to	The Positive and Negative Affect Scale (Watson et al., 1988) & Satisfaction with Life Scale (Diener et al., 1985)	+0.13	Australia
24	Sani, Madhok, Norbury, Dugard, & Wakefield	2015	Social Psychiatry and Psychiatric Epidemiology		1800	Adult general practitioner attendees	Group Identification Scale (Sani, Madhok, Norbury, Dugard, & Wakefield, 2014)	Major Depression Inventory (Bech, Rasmussen, Noerholm, & Abildgaard, 2001)	+0.36	Scotland

No.	Authors	Year	Journal	Study	N	Population	Multiple group membership measure	Psychological wellbeing measure	Overall wellbeing effect size ( <i>r</i> )	Country
25	Witherspoon, Schotland, Way, & Hughes	2009	Applied Developmental Science		437	Adolescents	Network of Relationships Inventory (Furman & Buhrmester, 1985), Psychological Sense of School Membership Scale (Goodenow, 1993) & 10-item Neighborhood Connectedness Scale	Rosenberg Personal Self-esteem scale (Rosenberg, 1965)	+0.28 <sup>a</sup>	United States - 29% Chinese American, 26% White, 23% African American, & 11% Puerto Rican
26	Ysseldyk, Haslam, & Haslam	2013	Aging and Mental Health	1	42	Older adults from structured care homes	8-item Exeter Identity Transition Scales (Haslam et al., 2008)	Geriatric Depression Scale (Sheikh & Yesavage, 1986)	+0.39	Canada
27				2	7021	Older adults - English Longitudinal Study of Ageing at Wave 1	Total number of groups to which participants belong to	4-item depression scale	+0.16 <sup>a</sup>	United Kingdom

<sup>a</sup>Effect sizes obtained were controlled for other variables (e.g., demographics)

## Footnotes

<sup>1</sup> The moderating effect of culture on the relationship between multiple group membership and depression is weaker when controlling for age and gender.

## Chapter 6: Conclusion

This thesis used a social identity perspective to interrogate ways in which the expression of depression is culturally shaped. Three lines of research were presented examining the cultural factors associated with (a) the symptomatic presentation of depression, (b) vulnerability to depression, and (c) resilience to depression. The key findings from each are summarized below. The results of this thesis highlight that it is through understanding the cultural underpinnings of depression expression that we are able to move beyond simply observing a relationship between culture and depression, to a position where this relationship and various influences can be explained and understood.

### **Shared Identities Provide a Basis for Social Influence: Understanding Cultural Differences in Symptomatic Presentation of Depression**

Previous research on Asian somatization has revealed mixed findings — at times, Asians somaticize depression and at other times they do not. Chapter 2 provides a new perspective on the processes and conditions under which culture and cultural norms influence depression expression. Drawing on social identity theorizing (and particularly on how shared identities can act as a basis for social influence; Tajfel & Turner, 1979; Turner, 1991), the research helps to understand *when* and *how* culture affects depression expression by showing empirically that cultural norm endorsement occurs only when individuals *identify* with their culture. Specifically, among Asians, it is only when they identify with the Asian culture that its normative expectations have the power to shape behaviors — even to the extent of influencing the manifestation of depression symptoms (i.e., somatization). Importantly, this highlights how social identification processes are central in the understanding of cultural influence.<sup>6</sup>

In the social identity approach (SIA), it is predicted that when cultural identity is salient, cultural norms associated with that identity will influence the expression of depression. However, it is worth noting that the studies conducted did not experimentally manipulate both cultural identity and cultural norms. Therefore, this does not allow us to establish whether normative expectations are identity based. Future research should therefore aim to manipulate the saliency of culture as well as normative expectations. Notwithstanding this, the findings have implications for practitioners working with people from Asian cultures. The findings suggest that mere knowledge of a person's culture is not predictive of whether

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<sup>6</sup> In understanding the influence of culture on one's beliefs and behaviors, other factors may influence this process (e.g., whether one is in a process of acculturation)



individuals somaticize. Rather, what is key, is identification with culture, and norm endorsement.

### **Social Norms Matter: Understanding Cultural Factors Associated with Vulnerability to Depression**

A growing body of literature finds evidence that the Western emphasis on the pursuit of happiness (and avoidance of unhappiness) may rather ironically create a vulnerability to depression (Bastian et al., 2012; Ford, Shallcross, Mauss, Floerke, & Gruber, 2014). Much of this work has centered on an individual's pursuit of the goal of striving for happiness (i.e., wanting and valuing happiness at a personal level). However, it has been argued that social and cultural contexts can play a role in reinforcing such messages regarding the value of happiness and unhappiness (Bastian, 2013). Furthermore, in the social identity approach, it is social norms or social perceptions (rather than individual-level perceptions) that are conceptualized as socially potent (Jetten & Haslam, 2016). In Chapter 3, we therefore adopted a *collective-level* approach to characterizing beliefs about emotions (i.e., as specific cultural factors subjective to normative influence). Specifically, we extended this research by investigating whether, and why, there are cultural differences in the relationship between happiness norms and depression in Asian and Western contexts.

The results showed that the paradoxical association between happiness norms and depression was not a universal phenomenon, and that this relationship was specific to Western contexts. That is, happiness norms were found to be associated with higher levels of depression symptoms among Westerners, but lower levels among Asians. Additionally, we found negative self-evaluations in response to unhappiness to mediate this relationship for Westerners only. The evidence suggests that valuing happiness may backfire on the wellbeing of Westerner, but not Asian. This is possibly because in Western contexts, norms for happiness are especially salient, and this may promote negative self-evaluations when people experience unhappiness. By contrast, in Asian contexts, where such norms are less salient, the influence of such negative self-reflections would be reduced.

A limitation of this study is the cross-sectional nature of the data, which does not allow us to make causal inferences about the directionality of effects. However, it is worth noting that we tested alternative models, and they did not provide a superior fit for the data. Additionally, it remains unclear why happiness norms would be associated with lower levels of depression symptoms among Asians. One possible explanation for this is that happiness may be more likely to be pursued in socially engaged ways (i.e., through social engagement)

in Asian, relative to Western, cultures, which in turn, promote wellbeing (Ford et al., 2015). This explanation could be examined in future work.

The study in Chapter 4 extended this line of research to investigate whether cultural differences in unhappiness norms are responsible for the cultural variation in the negative emotion-wellbeing link that is commonly observed. Here, negative emotions have been shown to adversely influence the wellbeing of Westerners to a greater degree than is the case for Asians' wellbeing (e.g., Consedine, Magi, Cohen, & Gillespie, 2002; Curhan et al., 2014; Kitayama et al., 2015; Kuppens, Realo, & Diener, 2008; Miyamoto et al., 2013). The results showed that social norms for unhappiness accounted for the moderating effect of culture on the unhappiness-depression link. In other words, unhappiness was more detrimental to individual wellbeing in Western contexts because unhappiness was viewed as more undesirable. By contrast, in Asian contexts, unhappiness was found to be less impactful on individual wellbeing because unhappiness was construed as more desirable and acceptable. This highlights that cultural variation in unhappiness norms can help understand why negative emotions may be less impactful on the wellbeing of Asians relative to Westerners. However, a limitation of this study is that we focused only on one negative emotion (i.e., unhappiness), and this was measured with a single item. In examining the explanatory mechanism for cultural differences in the negative emotion-wellbeing link, future work should explore and replicate the findings with other discrete negative emotions.

Together, the studies in Chapters 3 and 4 demonstrate the value of conceptualizing beliefs about emotions as cultural norms, which can advance our understanding of the relationship between culture and depression. Specifically, we showed that compared to Asians, normative beliefs that happiness is desirable and unhappiness is undesirable have the potential to make individuals in Western cultures feel worse (i.e., more depressed). Importantly too, these norms can help explain cultural variation in the negative emotion-wellbeing link. This highlights the socially potent nature of cultural norms, and accordingly, the importance of examining them in the study of culture and depression.

### **Shared Identities Provide Identity Benefits and Resources: Understanding Cultural Factors Associated with Resilience to Depression**

Previous studies have consistently shown that belonging to multiple groups protects against the development of depression (e.g., Cruwys et al., 2013; Cruwys, South, Greenaway, & Haslam, 2015; Sani, Madhok, Norbury, Dugard, & Wakefield, 2015a). According to the social identity approach to health, this is in part because individuals who belong to a greater number of groups have more sources from which to draw social support in times of

vulnerability and stress (Haslam, Cruwys, Milne, Kan, & Haslam, 2015; Haslam, Jetten, Postmes, & Haslam, 2009; Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009; Jetten, Haslam, & Haslam, 2012). However, these studies have been conducted primarily in Western cultures. More importantly still, it has been suggested that Asian cultural norms about relationships could make Asians more sensitive to the negative relational consequences of support seeking when compared to Westerners (e.g., burdening others; Kim, Sherman, & Taylor, 2008; Taylor et al., 2004). Hence, in Chapter 5, we questioned whether multiple group memberships protect against developing depression for Asians to the same extent as Westerners. Overall, our findings provided evidence of cross-cultural variation in the relationship between multiple group membership and wellbeing (e.g., depression) — belonging to multiple groups benefited the wellbeing of Asians to a lesser extent than Westerners. We also found that social support mediated the relationship between multiple group membership and wellbeing for Westerners only. It was argued that this could reflect Asian norms about relationships and support seeking, making Asians more reluctant to enlist social support due to concerns about burdening others. Here, it is worth noting that another possible interpretation of our findings is that Asians may derive fewer wellbeing benefits from multiple group memberships because of their need to fulfill obligations (e.g., to reciprocate support; Rothbaum, Pott, Azuma, Miyake, & Weisz, 2000). Future work should examine this explanation. Nevertheless, these findings underscore that cultural backgrounds and norms influence the extent to which individuals utilize and benefit from their social resources associated with group memberships, which in turn, impact on their wellbeing and depression.

### **Implications and Overall Conclusion**

Two broad conclusions can be drawn from the three lines of research conducted in the thesis. First, all nine studies show that culture affects the way that people experience depression. This cultural influence extends not only to the symptomatic presentation of depression, but also, to vulnerability and resilience factors of depression. Second, this research shows the utility of social identity processes and mechanisms (i.e., cultural identification, cultural normative expectations, multiple group memberships) in explaining the cultural underpinnings of depression. Across the studies, the articulation and empirical test of a social identity analysis of culture and depression represents a significant advance of the domains in which the SIA can be applied.

As demonstrated throughout the thesis, this framework offered the means to develop a novel analysis and understanding of process, thereby placing us in a better position to explain

the cultural underpinnings of depression. Additionally, similar to the normative approach of culture (Chiu, Gelfand, Yamagishi, Shteynberg, & Wan, 2010; Zou & Leung, 2015), this conceptualization is able to accommodate a central place for social variables in shaping the experience of depression for the individual. For example, all studies point to the importance of examining cultural normative expectations in understanding cultural influence.<sup>7</sup> This is particularly convincing in the data presented in Chapter 4. Here, it was shown that unhappiness norms could account for the commonly demonstrated cultural variation in the negative emotion-wellbeing link. The capacity to include social variables is pertinent because, despite increasing evidence demonstrating the importance of such variables in depression (Cruwys et al., 2013; Cruwys, Haslam, Dingle, Haslam, & Jetten, 2014), they have often been neglected due to the dominance of the biomedical model in psychiatry and clinical psychology (Deacon, 2013).

Worth noting too is that the SIA account of culture and depression goes beyond traditional cultural approaches in that it is able to explain within one framework the role of various social factors in shaping depression. Additionally, not only is the SIA able to account for social variables, it also allows for individual variation. That is, it is able to account for individual differences, which may arise through variation in identity strength. This was demonstrated in Chapter 2, where variability *within culture* in cultural identity strength predicted differences in depression expression (i.e., somatization). Taken as a whole, then, this underlines the parsimonious nature of SIA theorizing in understanding culture and its influences on the expression of depression.

The findings have important practical implications for clinical practice, as well as for campaigns or interventions promoting happiness and wellbeing. First, embracing the SIA to understand culture and depression can impact how we assist people who may be experiencing depression. For example, through considering social identification, we can understand the circumstances in which one draws on a particular identity to define themselves, and the extent to which that identity will influence behavior. This is particularly important because of the distinct implications identity has on beliefs, behaviors, and emotions (e.g., depression expression). Clearly, in the case of Asian somatization (as shown in Chapter 2), it is only when we have reflected on such social identity related factors that we can better understand whether (and the degree to which) the individual will be influenced by Asian culture and its normative expectations, and therefore, express depression in ways that are congruent with the

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<sup>7</sup> While we have examined both descriptive and injunctive norms in this thesis, their influences were not directly compared.

cultural norms. This suggests the importance of assessing cultural identification in therapeutic context, recognizing variability in the influence of culture and cultural norms.

Importantly, the SIA also recognizes that the influence of social identity and its content is context-dependent. That is, one will only be influenced by *salient* social identity and social norms (Oakes, Turner, & Haslam, 1991; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987; Turner, Oakes, Haslam, & McGarty, 1994). Thus, salience is key to understanding *when* individuals will be influenced by culture and its norms. Although this proposition was not directly tested in the thesis, there are good reasons to propose that this is likely to be generalizable to the study of culture and depression. For example, we know from a large body of existing evidence that individuals can switch cultural frame in response to contextual cues that make different cultural frames salient, assimilating their responses to that of the salient culture (e.g., Hong, Morris, Chiu, & Benet-Martinez, 2000). Further supporting this argument, health behaviors have been found to be driven by norms associated with identities that become salient for individuals in the moment (see Haslam et al., 2009, for review). For example, St. Claire et al. (2008) found that when participants were primed to think of themselves as a member of a group of people with colds, they reported more intense cold symptoms. The SIA therefore highlights that cultural influence is not constant. Therapists should therefore try to make sense of whether clients will be influenced by culture and its norms in a particular context.

Indeed, the value of some of these social identity related variables is recognized in cultural competence models, whereby therapists are expected to assess their clients' needs in the contexts of their cultural background and intervene accordingly and appropriately (Sue, Arredondo, & McDavis, 1992). However, apart from acknowledging cultural identity and its influence (e.g., culture accommodation model; Leong & Lee, 2006), such models have typically not taken into account identity salience, and other social identity related factors that may affect the extent to which one identifies with the culture. So, how could the social identity approach inform and extend models of cultural competence? First, the SIA would encourage recognition of variability *within* culture and the context-dependent nature of cultural influence. Second, it would advocate for therapists to think about clients in their social world (i.e., with a focus on the activated identities and normative expectations in any given context, see Ryder & Chentsova-Dutton, 2012, for similar argument) and determine how these might influence clinical outcomes. Third, a cultural understanding on how, when, and why culture and its norms shape depression is also necessary in establishing for whom (and when) psychotherapies need to be culturally adapted. Answering such key questions is

pertinent given that there is evidence supporting the effectiveness of culturally sensitive mental health treatment (e.g., making treatment consistent with the cultural context and cultural values of the client), including for depression (Huey Jr., Tilley, Jones, & Smith, 2014; Kalibatseva & Leong, 2014).

The findings from conceptualizing depression through the SIA lens also have important practical implications for the *type of interventions* designed to promote wellbeing and resilience to depression. As we noted above, a biomedical viewpoint of depression and psychopathology more generally has long dominated the mental healthcare system, particularly that in America (Deacon, 2013). However, in this thesis, we have shown that social identity processes play a role in understanding vulnerability and resilience to depression. This view is more compatible with the biopsychosocial model (Engel, 1977), where social factors are acknowledged to influence mental health. For example, in Chapters 3 and 4, our findings suggest that social norms communicating the acceptability of happiness and unacceptability of unhappiness may create a vulnerability to depression; albeit one that is associated more with Western, than Asian, contexts. Furthermore, in Chapter 5, we demonstrated shared group membership to play a key role in resilience to depression. Together, the evidence suggests that depression is, in part, socially shaped. What this highlights is the importance of targeting modifiable environmental (or social) variables that are associated with depression in treatment (see Cruwys et al., 2014; Cruwys, Platow, Rieger, Byrne, & Haslam, 2016, for similar argument on depression and disordered eating respectively). Consistent with this argument, a growing body of research shows the effectiveness of interventions that target underlying social psychological mechanisms such as social identity and social norms in various domains, including education (Oyserman, Bybee, & Terry, 2006; Oyserman, Terry, & Bybee, 2002), mental health (e.g., depression; Haslam, Cruwys, Haslam, Dingle, & Chang, 2016), disordered eating (see Cruwys et al., 2016, for review), and drinking and environment-conservation behaviors (see Miller & Prentice, 2016, for review).

Along these lines, our findings have direct relevance in the planning of social interventions to promote wellbeing and resilience to depression. The findings from studies in Chapters 3 and 4 suggest that social norms communicating the undesirability of unhappiness have the potential to make individuals feel worse (i.e., more depressed). Yet, such norms are constantly reinforced in our social contexts. For example, there are thousands of self-help books consigning negative emotions to the category of “problem emotions”. It is also the case that the discomfort from experiencing depression is often portrayed as easy to “cure” with a

range of drugs. In this regard, negative emotions are pathologized and medicalized, which in turn, may lead people to feel that their negative emotional experience is in some way abnormal (Bastian, 2013; Haslam, 2005). This hints at how social norms regarding the value of unhappiness should perhaps be communicated in national campaigns promoting wellbeing and resilience to depression. The present findings suggest that it may be good to minimize such perceived social pressures not to feel negative emotions (because they are undesirable and unacceptable). Indeed, this is reflected to some degree in the “third wave” within psychotherapy, whereby individuals are taught that negative emotions are an inevitable part of life, fostering acceptance of these emotions (albeit in an individual therapeutic context; Harris, 2007; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Strosahl, & Wilson, 2003). Here, it is worth noting that enacting normative change (i.e., changing the client’s environment) may be challenging in an individual-level context, but is conceivable at the group-level context (i.e., group intervention), whereby the group can be used as a resource to bring about normative social influence or normative change (reinforcing messages about the value of negative emotions; Cruwys, Haslam, Fox, McMahon, 2015). More research is however needed to understand the specific psychological mechanisms underlying happiness and unhappiness norms to better target leverage points and design simple, briefer, and more precise interventions for change (Walton, 2014).

Significantly too, our findings on multiple group membership and wellbeing in Chapter 5 support the use of social interventions targeting the building of group-based social identifications to enhance wellbeing and resilience to depression (Haslam et al., 2016; Tarrant et al., 2016). Notably though, the results suggest that shared group memberships may confer fewer wellbeing benefits for Asians, relative to Westerners, and this is due in part to Asian norms about relationships and support seeking. What this implies is that such interventions require cultural adaptations. Therapists may therefore need to work with Asian clients to tap into support resources in a mode consistent with Asian norms so as to allow them to fully benefit from the psychological resources their group memberships encompass. For example, some research has suggested that social support can in fact affirm Asians’ sense of the self as interdependent, but only if the support is unsolicited or implicit (Kim et al., 2008; Uchida, Kitayama, Mesquita, Reyes, & Morling, 2008). Consistent with this idea is the proposal that Asians can benefit from support obtained from their group memberships when in contexts where they do not have to disclose or discuss their problems (e.g., reminding oneself of close others; Kim, et al., 2008). In a similar vein, other researchers have highlighted that Asians can benefit from support derived from relationships which are perceived to be mutual and

interdependent (e.g., the individual had previously provided support; Wang & Lau, 2015). This suggests that Asians can use their shared group memberships for social resources and reap wellbeing benefits, but in different ways. As such, future research could explore these social support processes with relation to multiple group membership in greater detail, which will aid in the cultural adaptation of interventions.

### **Concluding Comment**

All in all, the present thesis aimed to advance our understanding of the processes and mechanisms underlying culture and depression expression. In particular, it adopts a social identity perspective to offer a new perspective on how, when, and why culture shapes depression and psychopathology more generally. The importance of considering these aspects is underscored throughout the thesis. The findings have implications for working with clients in clinical practice, and interventions promoting wellbeing and resilience to depression. It is clear that we are all profoundly influenced by the broader cultural frame in which we live, and yet, it is easy to overlook these influences in the context of one's own culture. This thesis has illustrated that the effects of culture on depression are best understood through a social identity lens.



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