contraception, and safer sex. Many would argue that U.S. health agencies have been more sensitive to cultural values in the international arena than they have in the domestic context. The ethnocentric assumption that the health promotion strategies that have worked in European American populations will also work with other racial and ethnic groups has long been challenged by researchers and practitioners who work closely with Hispanic, African American, and Asian groups in the United States. This challenge has been based on an awareness of the importance of cultural values to health behavior. The HIV/AIDS crisis extended this awareness to the general population with more public discussions of how different groups think about and engage in sexual practices. Groups varied in their beliefs about high-risk practices, the importance of family, the influence of religion, and the sanctity of marriage. These beliefs, in turn, influenced their attitudes and behaviors regarding sex and other health practices.

The four articles in this section focus their attention on how cultural values influence the health practices of Hispanics in particular. The authors draw on a broad spectrum of evidence, gathered using different empirical methods and built on research literature from a variety of fields. They all explore how certain beliefs regarding the importance of family, the individual, friends, and language influence how Hispanics respond to health messages and their willingness to participate in health programs. The research findings are interpreted in the context of the U.S.-Mexico border environment, accounting for differences in class, language proficiency, and immigrant status where appropriate.

Chapter 1

A MILE AWAY AND A WORLD APART

The Impact of Interdependent and Independent Views of the Self on U.S.-Mexican Communications

SHEILA MURPHY

The way in which we think of ourselves in relation to others can dramatically shape the way we structure our communications, our relationships, and our lives. A growing body of research suggests that our view of ourselves—alternately referred to as our *self-construal, self-schema, self-concept,* or *self-orientation*—may not be universally shared but rather may be heavily dependent on cultural context. For example, Markus and Kitayama (1994) argued that although most cultures place some value on both individual autonomy and the good of the group, the relative emphasis placed on individualism and collectivism can vary dramatically across cultures. They noted that Western cultures such as the United States tend to extol the virtues of independence, personal achievement, and the development and maintenance of a separate and unique identity. Markus and Kitayama juxtaposed this Western worldview against that of Eastern cultures, where people tend to view themselves not as individuals but as fundamentally interconnected with others, rather like a single thread woven into an intricate fabric. Consequently, the focus in Eastern cultures is one

of the "self-in-relation-to-other people," in which the self is virtually defined by group membership and interpersonal relationships. Thus, according to Markus and Kitayama, Western cultures tend to emphasize the individual and being *independent* by asserting one's rights and showcasing one's unique talents and abilities (see also Shweder & Bourne, 1984), whereas Eastern cultures tend to stress *interdependence,* or maintaining group harmony and relationships (see also Bond, 1986; Hui, 1988; Miller, 1988).

These divergent views of self are more than passive cognitive representations. Rather, they play a pivotal role in motivating and regulating behavior (Markus & Wurf, 1987). The behaviors of an individual with a more independent worldview are guided by the individual's own thoughts, feelings, and actions. Individuals are expected to become self-reliant, ensuring that their own needs are met. The behaviors of an individual who has an interdependent self-construal, in contrast, are determined by a consideration of the thoughts, feelings, and actions of others with whom the individual has a social relationship. Thus, in interdependent cultures, group or family needs are typically placed above the needs of the individual (Triandis, Brislin, & Hui, 1988).

An independent or interdependent self-construal is often seen as the individual-level manifestation of an emphasis placed on individualism or collectivism at the national level (Gudykunst, Matsumoto, Ting-Toomey, Nishida, & Heyman, 1994). Yet as Markus and Kitayama (1994) were careful to point out, these orientations should be regarded as general tendencies that emerge when members of a particular culture are considered as a whole. Consequently, although a particular self-orientation may be predominant in a given culture, there will be considerable variation among individual members. Moreover, there may be dimensions other than independent-interdependent that also differentiate between cultures, such as the need for approval or the need for control (Salzman & Hunter, 1983). These issues notwithstanding, the premise of the present chapter is that, like the Eastern cultures described by Markus and Kitayama, Mexican culture may promote a more interdependent or collectivist self-orientation that may at times be at odds with the predominantly independent worldview of the United States.

What are the consequences of these divergent self-orientations for interpersonal communication generally and for health care communication more specifically? As Witte and Morrison (1995) pointed out,

> Meaning, or understanding, is often influenced by the communication context and the interpretive assumptions that each person holds. In the health context, members of different cultures often bring different sets of interpretive assumptions to a communication interaction. For health professionals to help their patients or audiences, they must understand the interpretive frameworks within which their clients communicate. (p. 216)

A failure to recognize and be sensitive to alternate self-construals may result in rampant confusion, expectancy violation (Burgoon, 1995), and miscommunication. The remainder of this chapter attempts to show how Markus and Kitayama's (1991, 1994) theoretical framework regarding independent and interdependent self-construals may provide valuable insight into problems that commonly arise in health care communications along the U.S.-Mexico border. More specifically, the chapter will focus on two major sites of potential miscommunication—end-of-life decision making and sexual decision making—to illustrate how beliefs and behaviors that violate the normative expectations of an independent worldview might be better understood from an interdependent vantage point.

End-of-Life Decision Making

As discussed previously, the defining difference between an independent and an interdependent view of the self is the extent to which others are integrated into one's self-concept. Although others play a crucial role in any self-schema, individuals having an interdependent orientation see themselves as being defined primarily through their relationship with others (e.g., self as mother, coworker, or friend). One outgrowth of this emphasis on relationships is that individuals from interdependent cultures tend to be acutely aware of the feelings of those with whom they interact. From an early age, one learns not to burden others with one's problems. As a consequence, individuals from interdependent cultures tend to ignore or downplay illness as long as possible (Geissler, 1994). Such stoicism is evident in Mexican culture, particularly among Mexican males, for whom health is seen as an indicator of strength and manhood (Haffner, 1992). Mexicans, particularly those from rural areas, may turn to folk medicine first and to Western-style medicine only as a last resort (see Witte & Morrison, 1995, for a discussion of medical pluralism). As a result, diseases such as cancer or diabetes have often progressed much further among patients of Mexican descent by the time they first seek formal medical attention. In fact, it is not uncommon that by the time Mexican patients present themselves for treatment, they are close to death.

The issue of how terminal illness is handled is a prime example of the different worldviews that operate in U.S. and Mexican culture. Physicians in the United States strictly adhere to the principle of patient autonomy, which requires that the patient make informed decisions about his or her own medical care. In other words, patients should be fully informed about even fatal illnesses, be told the risks and benefits of proposed treatment options, and be allowed to make choices based on this information. Consequently, in the United States, it is standard practice for the doctor first to inform the patient of his or her diagnosis and prognosis, leaving it to the discretion of the patient whether to inform family members. Individuals from cultures having more interdependent orientations, such as Mexico, tend to prefer the exact opposite sequence of events—namely, first informing the family and leaving it to their discretion whether to inform the patient.

Thus, whereas those with independent orientations feel that the patient should be informed of a terminal diagnosis, individuals with more interdependent orientations feel that the patient should be protected from this news at all costs (Lock, 1983). This distinction was borne out in a study that my colleagues and I conducted (Blackhall, Murphy, Frank, Michel, & Azen, 1995). In the first year of this study, we conducted structured quantitative interviews with 800 individuals over the age of 65 living in the Los Angeles area—200 of Mexican descent, 200 of African descent, 200 of Korean descent, and 200 of European descent. These interviews were performed in the respondents' primary language. In the second year, ethnically matched anthropologists who specialize in each of these four ethnic groups performed in-depth ethnographic interviews with 10% of the original sample, providing context to the earlier quantitative data. These interviews covered a wide range of topics, from general attitudes toward Western medicine to more specific attitudes regarding end-of-life decision making. Of specific interest for present purposes are the differences between the Mexican[1] and European American respondents toward disclosure of a diagnosis and prognosis of a terminal illness and toward end-of-life decision making.

As shown in Table 1.1, individuals of Mexican descent were far less likely to agree that a patient should be told the diagnosis of cancer (48%) than individuals of European descent (87%). Moreover, less than half of our Mexican respondents felt that the doctor should reveal a terminal prognosis to the patient (48% compared to 69% for the European Americans). With regard to the question of whether to keep the patient alive on life support, Mexican respondents were more likely to nominate the family (45%) than the patient (41%) as the primary decision maker.[2] These results

TABLE 1.1 Degree of Patient Autonomy as a Function of Ethnicity

	European American	*Mexican American*	*Korean American*	*African American*
Physician should tell patient about metastatic cancer diagnosis[a]	87%[a]	48%[b]	35%[c]	89%[a]
Physician should tell patient about terminal prognosis[b]	69%[a]	48%[b]	35%[c]	63%[ab]
Who should make decision on life-prolonging technology:				
Patient	65%[a]	41%[bc]	28%[c]	60%[ab]
Family	20%[a]	45%[b]	57%[b]	24%[a]

NOTE: Percentages in the same row that do not share subscripts differ at $p < .05$.
a. "A doctor diagnoses a person as having cancer that has spread to several parts of their body. The doctor believes that the cancer cannot be cured. Should the doctor tell the patient that he or she has cancer?" (percentage answering yes).
b. "The doctor believes that the patient will probably die. Should the doctor tell the patient that he or she will probably die?" (percentage answering yes).
c. "The patient becomes very ill, and a decision must be made about whether to put the patient on life-prolonging machines. The machines will prolong the patient's life for a little while but will not cure the illness and may be uncomfortable. Who should make the decision about whether the patient is put on the machine?"

suggest that Mexican culture may promote a more family-centered model of medical decision making that runs counter to the prevailing U.S. model of patient autonomy.

One could argue that this pattern of findings is due, not to differing self-orientations, but rather to differences in social class. This was not the case. Great care was taken to recruit individuals in each of the four ethnic groups with roughly equivalent levels of education and income. Moreover, statistical analyses that hold income and education constant across the four ethnic groups reveal that ethnicity, not socioeconomic status, is the factor that underlies this pattern of results.

Indeed, some of our Mexican respondents thought it strange that the doctor would ask a patient to make this decision and suggested that perhaps this was a sign of incompetence. As Haffner (1992) noted, Mexicans typically "expect physicians to make the decisions for them and do not understand why they are asked to make choices. They are used to, and seem to prefer, deferring to experts" (p. 257). Our Mexican respondents also had a difficult time comprehending why a doctor would offer a seemingly futile

treatment such as mechanical ventilation. Many resolved their dissonance by concluding that although the treatment was described in pessimistic terms, the doctor must actually believe that the mechanical ventilation could provide some benefit to the patient because he certainly would not waste such a valuable medical resource. This logic led some of our respondents to the interpretation that perhaps the doctor held out hope for recovery after all. It is easy to understand how such an interpretation could lead patients and their families to accept what is, in reality, futile treatment.

Along related lines, many respondents felt that they must not decline any treatment that a doctor suggests. This is consistent with Haffner's (1992) assertion that "Latinos[3] feel that they should agree with physicians out of respect, even when they really disagree or do not understand the issues involved" (p. 257). This politeness and respect norm can lead physicians to conclude erroneously that the patient and family are in agreement on a proposed course of action when in actuality they are strongly opposed (Klessig, 1992).

This overarching concern for the feelings of others is consistent with an interdependent construal of self. In Japan, for instance, there are strict cultural prohibitions against disturbing the *wa*, or the harmonious flow of social relations (Markus & Kitayama, 1991). A similar concept, *simpatia*, in Mexican culture "mandates politeness and respect and discourages assertiveness, direct negative responses, and criticism" (Lifshitz, 1990, p. 17). *Simpatia* involves respecting and empathizing with the feelings of others and remaining agreeable even under difficult circumstances (Church, 1987; Triandis, Marin, Lisansky, & Betancourt, 1984).

Simpatia is clearly evident in the reaction of Mexican family members to a patient. Someone who is ill is seen as incapable of making decisions (Muller & Desmond, 1992). Moreover, if the prognosis is grim, the patient must be shielded from the truth. The following excerpt from Haffner (1992), which describes a typical day in a Texas hospital, illustrates this point:

> When I arrive, the patient's family is distraught. They request a conference out of the patient's presence. The physician tells the family that the mother is dying and needs radical surgery, but he emphasizes that the surgery would prolong her life only a little. The physician wants to tell the patient and ask for her consent to the operation. The daughters are very upset and against saying anything to their mother. They beg me to explain that their mother has the right to have hopes, that she should not be told that she is going to die, and that a painful and difficult operation that may buy her only a little more time is cruel. The result is an impasse that goes on for several days. The daughters vigilantly watch their mother, guarding her from the physicians, and hiding the truth from her. (p. 257)

Even in the face of terminal illness, the illusion of health is maintained by the family. Although at some level both the patient and the family realize that death is imminent, the family will assure the patient that he or she is "looking better" and "will be ready to return home soon." These practices, which are mandatory in Mexican culture, are in direct conflict with the Western medical establishment's ideal of patient autonomy and informed consent. This culture clash may be further exacerbated by the tendency of cultures that foster independent self-construals to favor very direct and linear forms of communication that "get straight to the point" and avoid "beating around the bush." Interdependent cultures, on the other hand, tend to favor a more indirect and subtle form of communication and perceive a direct recitation of the facts as cold and uncaring (Kim, 1995).

It is also noteworthy that the concept of "family" often varies as a function of self-orientation. In independent cultures such as the United States, the term *family* is commonly used in reference to one's nuclear family—namely, parents, siblings, and perhaps grandparents. Within interdependent cultures such as Mexico, however, the term has a much broader meaning. First, second, and possibly even third cousins may be included, as well as several friends of the family who are not connected by either blood or marriage. Consequently, the number of individuals who feel they have a right to be involved in the patient's health care decisions may vary dramatically by culture.

This is not to suggest that the more interdependent family-centered model of decision making is democratic. Rather, authority runs from oldest to youngest and from male to female, with the eldest male expected to receive diagnoses and make decisions regarding treatment for females and younger males (Haffner, 1992). Many physicians in the United States are taken aback to discover that a Mexican mother may not feel she has the authority to make decisions regarding medical treatment for herself or for her child (Geissler, 1994; Rasinski, 1993). Moreover, in Mexico, this patriarchal hierarchy is observed throughout the life span, with older adults continuing to make health care decisions for their adult children (Poma, 1987).

Such deference to one's elders and the past is common among societies with a predominantly interdependent orientation (Markus & Kitayama, 1991, 1994). Cultures that have a more independent worldview, in contrast,

often have a more future orientation. It is no accident that the notion of advance care planning, which allows individuals to retain control over their fate even when unconscious, was conceived in the United States. Advance care directives for health care have been widely promoted as a way to improve end-of-life decision making. These documents allow a patient to state, in advance of incapacity, the types of medical treatments he or she would like to receive (a "living will"), to name a surrogate to make those decisions (a durable power of attorney for health care), or both.

The principle of patient autonomy is so ingrained in the more independent U.S. culture that the benefits of such advance care planning seem obvious. Indeed, it has been argued that if individuals simply had sufficient information about and access to advance directives for health care, such as a living will or a durable power of attorney, they would complete them (Emanuel, Barry, Stoeckle, Ettleson, & Emanuel, 1991). To test the validity of this statement, my colleagues and I (Blackhall et al., 1995) asked the following question: If all individuals were equally educated with regard to advance directives, and if the requisite documents were readily available, would we see a uniformly high completion rate across all ethnic groups?

Our results, presented in Table 1.2, suggest that planning ahead may be a value associated with a more independent self-orientation (see also Lipson & Meleis, 1983). Although a complete lack of knowledge virtually precludes possessing either a living will or a durable power of attorney for health care, having knowledge ensures neither a positive attitude toward nor possession of an advance care directive. Our 200 Mexican respondents, despite a fairly high level of knowledge (47%), expressed a negative attitude toward written directives and had a fairly low rate of possession (10%). Those respondents who actually possessed a directive tended to have lived for a long time in the United States and were significantly more acculturated, as measured by Marin's Short Acculturation Scale (see Murphy et al., 1996, for more detail).

Compared to European Americans, Mexicans as a group had a negative attitude toward the concept of advance decision making. Two thirds of our Mexican American respondents endorsed items such as "Doctors should not discuss death and dying with their patients because it could be harmful to the patient" and "It is not necessary for people to write down their wishes about medical care because their family will know what to do when the time comes," compared to less than one third of their European American counterparts. These results further support the contention that Mexicans tend to place greater emphasis on family-centered, as opposed to patient-centered, decision-making styles (Blackhall et al., 1995).

TABLE 1.2 Knowledge and Possession of Advance Care Directives as a Function of Ethnicity

	% With Knowledge of Either a Living Will or a Durable Power of Attorney for Health Care	*% Who Possessed Either a Living Will or a Durable Power of Attorney for Health Care*
Mexican Americans	47	10
European Americans	69	28
Korean Americans	13	0
African Americans	12	2

Even after the concept of advance care planning was explained and the requisite forms provided, respondents of Mexican descent were decidedly uninterested in completing an advance care directive. This outright rejection was probed further in subsequent ethnographic interviews. When asked why they felt negatively about advance care planning, the Mexican respondents frequently mentioned a sense that the future was in God's hands and that assuming that one could "plan" one's death was an affront to God—an affront for which he might seek retribution. This resonates with Klessig's (1992) assessment that for Mexicans, "Health is a gift from God, and ill health, including accidents, may be due to punishment from God or the saints. The suffering incurred is part of God's plan and should not be interfered with" (p. 321).

God and religion play a major role in Mexican health care beliefs and practices. When asked to state their preferences with regard to medical treatment, a common response among our Mexican respondents was "if God wants" *("si Diós quiere")*. Physicians in the United States often mistakenly interpret this response as indicating that the patient does not want any medical intervention. This is not necessarily the case. As discussed previously, patients of Mexican descent may be uneasy when asked for input with regard to their medical treatment, feeling instead that God, or the doctor, should make the decision. Unfortunately, a strong belief in fate and God's omnipotence tends to be negatively correlated with perceptions of self-efficacy and control over one's life (Bandura, 1989). Witte and Morrison (1995) proposed that such a perceived lack of control may result in a fatalistic outlook and diminished health care with individuals espousing a "when it's my time to go, it's my time to go" (p. 239) attitude. This fatalistic

attitude has dire implications for the ability of health care professionals or health campaigns to change behavior, for individuals who believe that they have no control over their future will not be motivated to adhere to a treatment regimen or to alter their current activities and lifestyle.

Sexual Decision Making

This perceived lack of control over one's fate is evident in the response, or lack thereof, among individuals of Mexican descent to the AIDS epidemic. The rate of human immunodeficiency virus (HIV) infection for individuals of Mexican descent is among the fastest growing in the nation (Centers for Disease Control and Prevention [CDC], 1995). Although they constitute only 8% of the population, this group represents 16% of reported AIDS cases nationally (CDC, 1995). In other words, among known HIV cases, individuals of Mexican descent are dramatically overrepresented with respect to their prevalence in the general population.

A variety of cultural and economic factors have been posited to explain the elevated rate of HIV among both Mexicans and Mexican Americans (Hernandez & Smith, 1990; Maldonado, 1990; Marin, 1990). Marin (1990) pointed to the double standard that exists in Mexican culture with regard to sexuality. Mexican men are often encouraged to have sex at an early age and to have multiple sexual partners, whereas women are differentiated into those who are"good" (e.g., faithful to a single partner) and those who are "bad" (e.g., sexually available outside marriage or stable relationships). Marin asserted that this double standard may serve to constrain the sexual activity of most women while increasing the sexual activity of men. As Klein and Wolf (1985) pointed out, this "good-bad" categorization of women may result in men's perceiving that wives, or women who may become their wives (*novias*), are not prime sexual targets and instead turning to other available partners to demonstrate "virility" (Carrier, 1985), including both male[4] (Klein & Wolf, 1985) and female sex workers, who are at particularly high risk for carrying the HIV virus (Peterson & Marin, 1988).

Consequently, for women of Mexican descent, a major source of HIV transmission is apt to involve the risky behavior of their male partner. An obvious solution to this problem is to encourage women to persuade their partners to use condoms. Unfortunately, condom use remains particularly low among this population (DiClemente, 1991; Moore, Harrison, & Doll,

1994; Weinstock, Lindan, Bolan, Kegeles, & Hearst, 1993). In one study for the CDC, over 40% of Latinas reported that they would have sex without a condom with a partner who was HIV positive, compared to only 15% of European American women (Harrison et al., 1991, cited in Moore et al., 1994). Unfortunately, this low incidence of condom use is reflected in the relatively high seroprevalence rate among Mexican American women. Over 20% of the women diagnosed with AIDS are Latina (CDC, 1995), although Latinas represent only 6% of the U.S. population (U.S. Bureau of the Census, 1990).[5]

In Latin American cultures generally, value systems may make negotiating safer sex problematic. First, discussions of sexual matters between men and women are often considered taboo, even between husbands and wives (Marin, 1990). Men of Mexican descent find it particularly difficult to talk about sexual matters (Marin, 1990). It has been suggested that Latinos may be reluctant to disclose their HIV status to their partners because they fear rejection and loss of emotional support (Des Jarlais, Chamberland, Yancovitz, Weinberg, & Friedman, 1994). This is, of course, consistent with an interdependent orientation, in which relationships are valued above all else. This silence, however, has deadly consequences. As Peterson and Marin (1988) pointed out, because Latinos do not disclose their sexual histories readily, the sexual partners of HIV-positive men may incorrectly assume that they are not at risk.

As might be expected from an interdependent orientation, Mexican women are extremely sensitive to the feelings, needs, and desires of their partners. For example, Weinstock et al. (1993) found that Mexican women are especially unlikely to use condoms when their partners respond negatively to their use. Marin (1990) suggested that the direct confrontation that might be necessary in insisting that one's partner use a condom is at odds with the cultural value of *simpatia,* which stresses the importance of smooth interpersonal relations (Triandis et al., 1984). Direct challenges to male partners regarding condom use may also be perceived as threatening *machismo* (Marin, 1990) and may result in rejection, abuse, or even accusations of infidelity.[6] Furthermore, as Maldonado (1990) argued, Latinas who are economically and emotionally dependent on their partners are unlikely to insist on condom use if their male partners resist.

Cultural beliefs that women should not be knowledgeable about sex may likewise reduce the motivation to seek out information about AIDS. In fact, knowledge regarding AIDS, as well as beliefs that using condoms can be an effective preventative measure against HIV, was significantly lower for Spanish-speaking compared to English-speaking women in fam-

ily planning clinics, even though information was provided in both Spanish and English (Rapkin & Erikson, 1990). But this lack of AIDS-related information is not limited to women. DiClemente, Boyer, and Morales (1988), in a study of high-risk adolescent males in San Francisco, found that white students were more knowledgeable about AIDS than were black students, who in turn were more knowledgeable than Latino students. Latinos also scored significantly lower in terms of AIDS knowledge on the 1988 National Survey of Adolescent Males (Sonenstein, Pleck, & Leighton, 1989).

What accounts for these relatively low levels of AIDS knowledge among Latinos? Similar trends have been found with regard to knowledge about sex and contraceptive use, suggesting that it is not AIDS per se that is a taboo topic but issues of sexuality more generally (Padilla & O'Grady, 1987). One especially relevant study examined contraceptive use and pregnancy among 300 women living on each side of the U.S.-Mexico border in the twin cities of El Paso and Juárez (Russell, Williams, Farr, Schwab, & Plattsmier, 1993). Whereas 94% of the women in El Paso, Texas, reported that they had heard about condoms, this was true for only 75% of the women in Juárez. In terms of actual use, the gap was even more dramatic, with almost twice as many of the women in El Paso reporting having used a condom (19.3% vs. 10.2% in Juárez). Furthermore, the most commonly used method of birth control in Juárez was the rhythm method (26.4%), whereas the most common method in El Paso was the pill (12%). Interestingly, women in Juárez also tended to hold the opinion that birth control methods are bad for one's health and that they are generally unreliable. Finally, whereas women in El Paso reported using birth control to avoid pregnancy, those in Juárez tended to frame birth control as a way to optimize the timing of children to ensure their health. Notice that these divergent explanations are consistent with the proposed independent (i.e., avoid getting pregnant) and interdependent (i.e., ensure health of child) views of self.

In sum, a fatalistic attitude about the future, a sense that illness may be a retribution for one's sins, religious prohibitions against condoms, a heavy emphasis on procreation, a reluctance to discuss sex or sexual history, and other associated behaviors and beliefs appear to result in a relatively low level of knowledge and a relatively high incidence of HIV. This constellation of cultural beliefs and practices presents quite a challenge for health care communication. The following section examines how being sensitive to divergent construals of self might make attitude change campaigns more efficacious.

Implications for Health Care Campaigns

Although much research has been directed at identifying factors that motivate people to protect themselves against health risk, the bulk of this research has targeted white middle-class Americans (Witte & Morrison, 1995). Not surprisingly, therefore, the vast majority of health care campaigns reflect an independent orientation. Typically, these health care campaigns attempt to coax the individual to engage in positive behaviors by appealing to his or her self-interest. This assertion was supported by a content analysis conducted by my colleague, Lynn Miller, and myself in conjunction with the CDC. We content-analyzed 101 television public service announcements, 45 radio spots, and 19 clinic brochures available in the greater Los Angeles area dealing with AIDS. Our analysis determined that the vast majority of these messages were independent in orientation in that they attempted to induce attitude and behavior change by appealing to the individual to act in his or her own best interest by "looking out for Number 1." In fact, the primary theme in over 75% of messages in each of these three media was "protect yourself" (see Miller, Murphy, & Clark, 1996, for details).

Although "protect yourself" may be an effective message in cultures that stress independence and self-efficacy, it may be substantially less effective in cultures that promote a more interdependent worldview. To individuals of Mexican descent who place heavy emphasis on relationships and family, messages that appeal to self-interest, such as "protect yourself," seem strange at best. Because these messages are at odds with their predominant cultural beliefs and values, it is unlikely that members of more interdependent cultures would possess either the motivation or the ability to integrate them into their everyday lives.

Messages that hope to motivate by appealing to self-interest may be particularly problematic for women. As alluded to previously, there is empirical evidence to suggest that the degree to which one ascribes to an independent orientation also varies *within* cultures (Markus & Kitayama, 1994). One fairly consistent finding is that women, regardless of cultural orientation, tend to be more likely to define themselves in terms of relationships (e.g., mother, sister) than men (Gilligan 1982; Jordan, Kaplan, Miller, Stivey, & Surrey, 1991) and to be especially concerned with maintaining relationships. That females in general would tend to be more interdependent in orientation makes intuitive sense in that traditional sex roles seem to parallel the independent-interdependent self orientations.

Whereas males tend to evaluate themselves on independent dimensions such as competition, individual achievement, and dominance, the female sense of self tends to be measured by the more interdependent traits of caring, cooperation, and empathy (Gilligan, 1982, 1987). Research also suggests that members of marginalized groups (e.g., nondominant ethnic groups, the poor, the unschooled, the elderly) share a more interdependent or group orientation (Markus & Kitayama, 1994). Thus, although independent-interdependent orientations may provide a useful tool to understand differences at the cultural level, we must bear in mind that there is substantial within-group variation and that some subgroups of the population may constitute cultures in their own right (Maltz & Borker, 1982).

Taken together, these findings should lead us to question the utility of health care messages that are individualistic in orientation for women generally and for Mexican women in particular. Lynn Miller and I are currently collecting data to address this issue. To identify the goals that these women see as most relevant to them, we asked Mexican and Mexican American women living in the Los Angeles area to list three things that they considered the most important in the world, three things that they hoped would happen in their life, and three things that they feared would happen. Whereas our content analysis revealed that the majority of the AIDS-related messages on TV, on the radio, and in clinic brochures in this area had a heavy independent emphasis ("protect yourself"), our respondents appeared to be far more likely to mention collectivist or interdependent themes such as protecting loved ones.

Although these data are preliminary, they suggest that in the Mexican community, the values of cooperation, community, and family responsibility might be more efficacious motivators in health appeals (see also Marin & Marin, 1991; Mays & Cochran, 1988). Effective messages must also enable women to circumnavigate intrapersonal, interpersonal, and cultural obstacles. For example, *machismo* might be harnessed in AIDS prevention campaigns by stressing the role of men as providers and protectors of the family (Marin, 1990). Also, Marin (1990) and Lifshitz (1990) suggested that rather than directly confronting religious beliefs regarding condom use, health care appeals tap into a major motivational source for Latinas—namely, staying healthy to continue to care adequately for their children. "Anything that jeopardizes her life also jeopardizes the well-being of her offspring. That awareness may provide the leverage that could persuade her to reconsider her feelings against condom use" (Lifshitz, 1990, p. 17). Perhaps a more effective message for this audience might involve more interdependent goals: for example, "Protect your loved ones" or "Who would take care of your family if something happened to you?"

According to Markus and her colleagues (Markus & Kitayama, 1991, 1994; Markus & Wurf, 1987), motivating individuals to action is an important function of the self-concept. Unfortunately, there is little systematic work examining how individuals with different self-orientations process health care messages and incorporate recommendations into their everyday lives. However, if we extrapolate from extant research, we might predict that individuals with an independent view of self would be motivated to act in ways that allowed them to express their self-defining inner attributes, such as being creative, autonomous, or unique. In contrast, individuals with a more interdependent orientation might be more likely to act on messages that allowed them to express feelings of relatedness or connectedness to others.

Conclusion

The premise of this chapter was that the United States, with its emphasis on freedom, equality, and individual rights, tends to foster an independent construal of self, whereas Mexico, with its reverence for family and its notion of *simpatia,* may promote a more interdependent construal of self. It was further argued that these divergent perspectives may result in intercultural confusion and miscommunication. A review of the relevant research seems to support these contentions.

It is important to bear in mind, however, that although independent versus interdependent self-orientations may provide a useful heuristic in understanding differences between cultures, it is a relatively gross categorization and, as such, is unlikely to characterize adequately every individual in every situation. Obviously, there are individuals within a given culture for whom these general self-construals do not apply. Nor should we expect an individual always to act in accordance with his or her primary self-construal.

Moreover, for the sake of simplicity, the present chapter focused primarily on a conception of self as put forward by Markus and Kitayama (1991), in which a culture tends to emphasize and promote either a predominantly independent value system or a predominantly interdependent value system. The relative weight assigned these value systems at the cultural level tends to be reflected in the self-orientations of its members. This is not to say that individuals cannot possess both value systems. Indeed, Triandis (1989) argued that these two aspects of self can coexist and emerge in different situations. For example, he suggested that a view of ourselves as independent may be more likely to emerge and guide our

actions when we are alone, whereas our interdependent view of self may be more accessible when in-groups are salient (Triandis, McCusker, & Hui, 1990).[7] The idea of more than one self-construal coexisting is not necessarily inconsistent with Markus and Kitayama's theoretical framework. Indeed, they explicitly stated that cultures and individuals possess both value systems to some extent and that which of the two self-construals—independent or interdependent—is more chronically accessible to the individual and therefore more likely to influence behavior tends to vary by culture.

The issue of whether the independent and interdependent aspects of self are orthogonal may have interesting implications with regard to the issue of acculturation. Shibutani and Kwan (1965) defined acculturation as the process of learning and acquiring some, but not all, aspects of a host culture. This raises an intriguing issue: Does acquiring elements of a new host culture necessitate "deculturation" from one's former culture? There is scant research with which to address this question. In one relevant study, Cross and Markus (1991) examined the self-construals of East Asian exchange students. Their results indicate that living in the United States resulted in an increase in the value that these students placed on independence but did not decrease the value they placed on interdependence. This seems to imply that independent and interdependent self-construals may be orthogonal and consequently can coexist. On the other hand, Russell et al.'s (1993) previously cited study of contraceptive use and pregnancy among young women along the U.S.-Mexico border suggests that although the physical distance between El Paso and Juárez is less than a mile, the psychological distance may be much further.

Many questions remain unanswered. For example, if an individual develops two distinct self-orientations, one that predominates in his or her native land and one that is stressed in the adopted land, which is likely to be more influential in terms of health care decisions? Barker (1992) argued that "no matter how acculturated a person appears, at times of great stress, such as illness or death, early-learned ideas resurface and structure responses" (p. 251). Although this has intuitive merit, there are no data either to support or to refute this assertion.

Finally, must acculturation involve a physical move to another country, or can it occur through constant mass media exposure to the values, beliefs, and behaviors of another culture? The mass media of host countries have been shown to facilitate the adaptation and acculturation of immigrants (Subervi-Velez, 1986). Moreover, Kang, Kapoor, and Wolfe (1996) found that among Indian viewers, support of individualistic values increased as a

function of the amount of time they spent viewing U.S. television programs. It may follow, therefore, that chronic exposure to a diet of mass media programming from a predominantly independent culture may substantially influence the self-orientation of interdependent viewers and vice versa.

Perhaps independent and interdependent views of self will provide a useful framework to address these and other questions. Clearly, further work is needed. It is important to keep in mind, however, that the purpose of distinguishing between independent and interdependent views of self is not to draw attention to differences and perpetuate cultural stereotypes. Rather, the goal is to sensitize readers and health care professionals to the cultural contexts and differing worldviews that individuals carry with them when they cross the border.

Notes

1. We refer to our respondents as "Mexican Americans," although the group consisted almost exclusively of Mexican nationals who had lived in the United States for various periods of time.

2. It is interesting to note the similarity between the responses of the Mexican and the Korean groups, both of whom appear to subscribe to a family-centered model of medical decision making. This similarity supports our contention that Mexican culture, like many Asian cultures, promotes an interdependent construal of self.

3. I am somewhat uncomfortable with the use of the terms *Latino* and *Latina* because they seem to clump individuals from many countries together, ignoring what may be significant cultural differences between Latin American subgroups (e.g., Cubans, Puerto Ricans, Mexicans). Though I prefer grouping individuals in clusters no larger than country of origin, Marin (1990) and others have argued that although there may be a number of important differences between Latin American countries, there is also significant overlap, suggesting that the single term may be acceptable. Although I agree that many cultures in Latin America share an interdependent orientation, I will use the more specific terms *Mexican* and *Mexican American* unless referring to research that employs the term *Latino*.

4. Interestingly, in Mexican culture it is not taboo for a man to engage in sex with a male prostitute. As long as the client is in the insertive role, this is not seen as a reflection on his own sexual orientation.

5. Unfortunately, male-to-female transmission appears to be an especially effective conduit, and women—83% of whom have contracted HIV through heterosexual sex—are currently one of the fastest growing segments of the AIDS epidemic (CDC, 1995). By the year 2000, it is expected that the number of women infected will surpass the number of men.

6. With regard to tolerance for infidelity, there is also a double standard. A married woman's engaging in sex with a man other than her husband is strictly forbidden and harshly punished. When a man cheats on his wife, however, it is often ignored or tolerated as something that will

pass without undermining the wife's position. This is illustrated by the saying "There are many chapels [other women], but the cathedral [the wife] should not be jealous of the chapels."

7. Along similar lines, Argyle (1991) noted that a number of cross-cultural studies suggest that individualism and collectivism are not opposites but rather separate orthogonal factors. This framework suggests four possible types of cultures: one type in which both values are high, one type in which both values are low, and two types in which one value is high and the other low.

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