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Incorporating the Cultural Diversity of Family and Close Relationships Into the Study of Health

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Relationships are at the center of the human social environment, and their quality and longevity are now recognized to have particular relevance for health. The goal of this article is to bring attention to the role of culture in how relationships, particularly close relationships and family relationships, influence health. To this end, 2 contexts that are characterized by 2 distinct forms of cultural collectivism (East Asian and Latino) are spotlighted to highlight the unique patterns that underlie broader cultural categories (e.g., collectivism). In addition, related research on other understudied cultures and nonethnic or nonnational forms of culture (e.g., social class, religion) is also discussed. The review centers on social support, a key pathway through which relationships shape psychological and physical health, as the psychological process that has received the most empirical attention in this area. Overall, it is clear that new and more systematic approaches are needed to generate a more comprehensive, novel, and inclusive understanding of the role of culture in relationship processes that shape health. Three recommendations are offered for researchers and professionals to generate and incorporate knowledge of culture-specific relationship processes into their understanding of health.

Keywords: culture, East Asian, Latino, family relationships, health

Culture is increasingly recognized by psychologists as a force that shapes all aspects of human social life. Culture is defined as a dynamic system with loosely organized but often causally connected elements (e.g., meanings and practices) that provide the information and knowledge needed to skillfully navigate one's social environments (Dressler, 2004; Kitayama, 2002). For all

people, culture provides a context that shapes priorities, access to meeting goals, and interpretation and evaluation of individual actions and social events (Kim & Lawrie, 2017). For many, culture is experienced as the invisible assumption of "normal." In contrast, relationships, especially family relationships and close relationships, are the salient center of the human social environment and, thus, central carriers of culture-specific goals (Kim & Lawrie, 2017). Research has made it increasingly clear that relationship quality and longevity are important for health (e.g., Holt-Lunstad & Smith, 2012) and that relationships and relationship processes are a key path through which culture influences health. The goal of this article is to press for the full integration of culture into the study of psychological mechanisms that link relationships and health. To this end, a conceptual framework is offered for blending the broad-level distinctions that have been so generative for cultural psychology with finer grained distinctions that are critical for advancing a more inclusive understanding of the cultural shaping of relationships and health that better captures the great diversity of human relationship experience. The growing literature on culture's role in social support processes, an important way through which relationships shape psychological and physical health, is then reviewed from this perspective.

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Belinda Campos

Culture and Relationships

Cultural psychological investigation in the past decade has yielded much knowledge about the role of culture in relationships. Research to date has confirmed that culture influences how people form, maintain, and terminate their relationships with family, partners, and friends (e.g., Hashimoto, Mojaverian, & Kim, 2012; Schug, Yuki, & Maddux, 2010). Notably, culture exerts these effects by shaping how people think, feel, and behave and how people expect others to think, feel, and behave in relationship contexts (Hofstede, Hofstede, & Minkov, 1997; Markus & Kitayama, 1991; Triandis, 1995). Around the same time, research has shown that relationships shape many aspects of health, from psychological and physical health to health maintenance to the length of life itself (e.g., Holt-Lunstad & Smith, 2012; Repetti, Taylor, & Seeman, 2002).

Relationships are central to cultural psychology's dominant theoretical frameworks—individualism–collectivism (Triandis, 1995) and independent–interdependent construal of self (Markus & Kitayama, 1991). Both address core processes through which individuals relate to others—whether priority is placed on the personal preferences of the self or on important relationships. Less dominant but equally broad sources of cultural variation—acceptability of power distance and gender roles, for example (e.g., Hofstede et al., 1997)—also address processes that chiefly unfold in relationships. Despite their theoretical usefulness, however, these broad-level frameworks pose a risk of masking the unique patterns of specific cultural contexts. For example, Glazer (2006) examined social support use across 20 countries from five geographic regions of the world (West-

ern European, Eastern European, Latin American, Asian, and English-speaking countries) in relation to cultural value dimensions (i.e., hierarchy vs. egalitarianism; mastery vs. harmony) and found that social support use was predicted by a combination of multiple cultural value dimensions, not just individualism–collectivism. This complexity poses a challenge for researchers who are not experts in human cultural variation but wish to situate their work in its cultural context and be guided in generative new directions.

Arriving at an understanding of cultural variation in psychological processes involved in family and close relationships that is both more comprehensive and nuanced is a necessary step toward a deeper understanding of how relationship processes may impact health. To take this step, one must consider finer grained distinctions that capture the specific features of particular cultural contexts within overarching cultural orientations (e.g., individualism–collectivism). A conceptual framework for capturing these finer distinctions can be derived from an analogy to color. As distinct colors are understood to stem from blends of primary colors, distinct cultures can be understood as unique blends of primary psychological constructs (i.e., independent–interdependent self-construal, valuation of specific emotional experiences and expression, acceptance of power differences, relational mobility). This allows for the reality that overarching orientations can manifest in different ways, with patterns that might otherwise be theoretically puzzling. As such, this conceptualization of culture as blends of multifaceted primary psychological constructs offers a means for integrating and synthesizing topics and research literatures that have been historically studied and discussed separately. In this article, this integration starts with two contexts whose distinct forms of collectivism have largely been studied separately—East Asian and Latino cultures. New terms and an overview for understanding these distinct forms of collectivism are presented. As will be seen, this allows for seemingly divergent findings from these cultures to be situated in a theoretically coherent space.

The integration is then extended via the review of research that draws from understudied cultures (i.e., eastern European, Mediterranean) and nonethnic or nonnational forms of culture (i.e., social classes, religions) to reflect recent developments in cultural psychology. The effort at integrating and synthesizing separate bodies of research also pertains to the domain of relationships and health. Close relationship research and family relationship research have largely existed in parallel (e.g., Berscheid & Reis, 1998), but effort was made to connect these two literatures as much as the existing body of empirical research allows.

It is important to note that there are many ways to address the question at hand, given the complex manners in which culture, relationships, and health are intertwined. In the present review, the primary focus is to understand how



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culture shapes *psychological processes* that link relationship and health because this mechanistic understanding is an element that is often overlooked in the relevant literature. Thus, this review centers around findings that incorporate a cultural analysis of how individuals see their close relationships and what they expect from them and, eventually, how these cultural expectations have implications for health outcomes.

Cultural Representations of Relationship: A Conceptual Analysis of Three Contexts

Although relationships are at the center of individual lives in all cultures, research has found that there is much variation in people's representations of what relationships are, how to manage relationships, and how to assess good and bad relationships. These cultural representations of relationship matter because they shape people's relationship expectations and goals; in turn, these expectations and goals have social behavioral implications that can impact health.

The cultural representation of relationships that is probably the more recognizable to the majority of readers is based in the cultural context of North American people of European, Protestant origins. This context is broadly individualistic with high relational mobility—the degree to which individuals have opportunities to voluntarily form and terminate relationships (Schug et al., 2010). In this cultural context, the potential gains of actions that express the self, such as self-disclosure and authentic emotion expression, are salient because they facilitate forging new relationships and maintaining positive relationships (Schug et al., 2010). The cultural contexts of East Asians and

Latinos, including Americans of these heritages, are broadly collectivistic with low relational mobility. As with all forms of cultural collectivism, it is normative and socially approved to perceive the self as interdependent with close others (Markus & Kitayama, 1991; Triandis, 1995) in these contexts. In both cultures, idealized ways to forge and maintain relationships differ at the broadest cultural level (i.e., collectivism–individualism) from European Americans. At the same time, East Asian and Latino cultures branch out from collectivism in ways that differ from each other; the two are quite distinct in the core emotion processes that are emphasized as the means to create and maintain interdependent relationships.

In East Asian contexts, a blend of collectivism that is presently termed *harmony collectivism* prevails. In this context, the potential costs of mismanaging existing relationships are salient, and East Asians are more negatively impacted by interpersonal conflicts and spend more effort preventing potential interpersonal conflicts than do their European American counterparts (Hashimoto et al., 2012). Thus, East Asians tend to navigate through their existing relationships with caution to avoid rattling them unnecessarily and placing a burden on close others (Kim, Sherman, Ko, & Taylor, 2006). Moreover, emotions are not considered to be a primary concern in East Asian cultural contexts. Experiencing high arousal emotions, even positive ones, is not valued (Tsai, Knutson, & Fung, 2006), direct emotional expression is not commonly exercised (Butler, Lee, & Gross, 2009), and relationship closeness and warmth are communicated by instrumental aids (e.g., practical advice) among close others more than by direct expression of positive emotions (Chen, Kim, Mojaverian, & Morling, 2012).

In Latino contexts, a blend of collectivism that is presently termed *convivial collectivism* prevails. In this context, interdependent relationships are actively built and maintained via open and frequent positive emotion expression, regular social gathering, and pleasant politeness that preserves the honor and dignity of self and others (e.g., Hirsch, 2003; Sabogal, Marin, Otero-Sabogal, VanOss Marin, & Perez-Stable, 1987). Three cultural values—*simpatía*, *respeto*, and *familism*—central to Latino culture capture this unique cultural representation (Hirsch, 2003; Holloway, Waldrip, & Ickes, 2009; Sabogal et al., 1987). *Simpatía* is the emphasis on creating and expressing emotional positivity, and avoiding negativity, in the service of smooth and enjoyable social interaction (Holloway et al., 2009). *Respeto* is the formal politeness that encourages civil discourse and avoidance of topics that might cause discomfort because they evoke embarrassment, conflict or are vulgar (e.g., Hirsch, 2003). *Familism* is the importance placed on having family relationships characterized by closeness; support; and frequent face-to-face, emotionally positive, social interaction (Campos, Ullman, Aguilera, & Dunkel Schetter, 2014; Sabogal et al., 1987).

These three cultural blends of primary psychological constructs that draw from overarching cultural orientations— independence, harmony collectivism, and convivial collectivism—shape the everyday practices that characterize close relationships and family relationships in their particular context and, consequently, the processes through which these relationships impact health. Among Americans of Northern European background, family has a special place as one's relationships of origin and is created anew through couples' long-term committed bonds (Coontz, 2005). However, individual independence is still prioritized. This is reflected in social practices such as spending less time with family members in adolescence, moving away from family of origin for college or jobs, and prioritizing personal preferences in the selection of life partners and professions (Coontz, 2005; Fuligni, 2007). Among both East Asians and Latinos, family of origin is a central feature of life throughout the life span. This priority on interdependence with family is visible through social practices such as spending time with family in adolescence, engaging in high levels of family assistance (e.g., caregiving, chores, financial support), and factoring in the preferences of one's family as life partners and professions are selected (e.g., Fuligni, 2007; Sabogal et al., 1987).

A core difference that sets apart the cultural contexts of East Asians and Latinos is the way emotions are managed to attain interdependence. Among East Asians, familial commitment is characterized as mutual duties or obligations of all to the family group. One important example is the notion of filial piety, which prescribes role-specific duties, such as obedience and loyalty on one hand and care and guidance on the other, especially in intergenerational family relationships (e.g., between grandparents, parents, and children; Ho, 1998). In this context, the primary emphasis is placed on moderating emotion expressions and fulfilling duties over personal preferences and wishes. Among Latinos, fulfilling familial obligations and providing support is also a duty but one that is expected to be emotionally positive and intrinsically rewarding. Frequent positive emotional interactions among family members are actively sought to affirm family bonds and duty fulfillment (e.g., Campos et al., 2014; Sabogal et al., 1987). Thus, how emotion is experienced and expressed is a salient contrast that differentiates these two blends of collectivism, with Latino culture valuing active pursuit and expression of positive emotion in relationships and East Asian culture valuing greater emotion balance in relationships.

Culture, Relationship, and Health

It is now well established that relationships, family relationships and close relationships in particular, are associated with better psychological and physical health. Relationships shape health outcomes spanning from daily

well-being to various forms of psychological distress and even to relapse rates of severe mental illness (S. Cohen, 2004; Lopez et al., 2004). Similarly, relationships shape physical health from the start of life via infant birth outcomes (Collins, Dunkel-Schetter, Lobel, & Scrimshaw, 1993) and continue throughout the life course via physiological processes that increase the risk of disease and chronic illness (Repetti et al., 2002; Uchino, 2009); relationships even play a role in the number of years lived (Holt-Lunstad & Smith, 2012).

The process showing how this link between relationship and health is impacted by cultural representations is visually represented in Figure 1. In all cultures, nurturing relationships allow individuals to grow to be secure, socially skilled, and likely to attain higher status and greater reproductive success (e.g., Hrdy, 1999). In contrast, family relationships lacking nurturance promote health-harming behavior and dysregulate stress-responsive biological systems in ways that contribute to long-term poorer psychological and physical health across the life span (e.g., Carlisle et al., 2012; Repetti et al., 2002). However, cultural representations of relationships (i.e., how people define and practice nurturing relationships) vary across cultures, and these differences are rooted in unique blends of the culturally primary psychological processes of self-construal, relational mobility, and valuation of experiences and expression of emotions. For example, East Asian cultures may practice a form of nurturing relationships that is less entwined with self-affirming emotional positivity than is found in European American cultures (Chao, 1994), and Latino cultures may practice a form of nurturing relationships that emphasizes other-focused positivity more than is done in European American cultures (Calderón-Tena, Knight, & Carlo, 2011). These different representations, in turn, shape processes that link relationships and health by influencing how individuals interpret the social interactions that surround them.

There are at least four key aspects of relationships that are linked with health (S. Cohen, 2004)—social integration, negative interaction, positive interaction, and social support. Of these, with the goal of focusing on processes that have been empirically established, the present review centers on social support because its social and psychological processes linking relationship and health are best identified in conjunction with culture. The findings from this area of research have shown considerable cross-cultural variation in what form, how much, when, how, and from whom people find support and, in turn, how they are impacted by the use of social support (e.g., Campos et al., 2008; Kim, Sherman, & Taylor, 2008). The contrast of East Asian and Latino cases continues in the following sections, primarily addressing social support as a mechanism through which relationships impact health and cultural shapes that overall link.

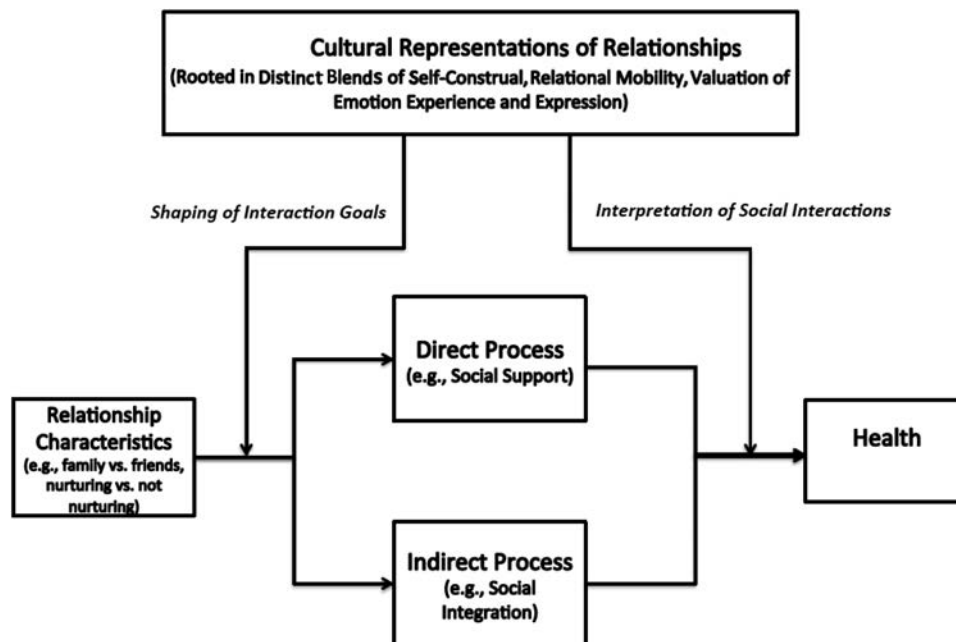


Figure 1. Theoretical model of cultural influence on the links between relationships and health.

Close Relationships and Health in East Asian Cultures

In East Asian cultural contexts, family, rather than individuals or dyads, is the basic unit of society (Cai, Sedikides, & Jiang, 2013; Ho, 1998). Family of origin relationships, which are lower in mobility, are prioritized over other higher mobility close relationships, such as friendships (Li, 2002) or even romantic relationships (Hsu, 1963). Within the family context, individuals are taught to strive for harmonious dynamics by focusing on role-bound duties and sacrifices for the family over one's own personal wishes (Ho, 1998). Thus, one's family and other close relationships are not necessarily considered as resources to draw from but rather as a social unit one should serve. This is not to say that family is a burden. Quite to the contrary, thinking of one's family and that one belongs to it serves as the most potent form of self-affirmation among East Asians (Cai et al., 2013). Further, the ideals of familial duties and sacrifices generalize to other important relationships, such as friendships and professional relationships.

In East Asian cultures, how social support is used and brings health benefits varies from Western expectations. The decision to solicit social support in East Asia reflects higher degrees of interpersonal cautiousness than in North America, even within the family and other close relationships (Kim et al., 2006). Studies have shown that East Asians and East Asian Americans are more concerned about negatively impacting their social network by involving close others in their troubles compared to European Americans (Kim et al., 2006; S. E. Taylor et al., 2004). As a

result, East Asians' and East Asian Americans' willingness to seek support in dealing with stressors is considerably lower than that of European Americans, and it is interesting that this difference is less pronounced with East Asian Americans, reflecting their exposure to the mainstream American culture (S. E. Taylor et al., 2004). This hesitation to seek support is found across all close relationships but is particularly strong when it comes to obligatory relationships, such as family, compared to discretionary relationships, such as peers (Wang & Lau, 2015).

Studies have also shown cultural differences in the psychological and health consequences of social support use among East Asians or East Asian Americans. Full understanding of social support outcomes requires consideration of how high-quality social support is characterized in the context of harmony collectivism. Empirical studies have found that in European American cultures, maintenance and restoration of positive emotional states and protection of self-esteem are the prioritized goals in support transactions (Chen et al., 2012). In contrast, in East Asian cultures, the primary goal is to assure interdependent connections among close others and build mutual reliance in problems solving (e.g., Chen et al., 2012). Consequently, greater relationship quality strongly predicts emotion-focused support provision in European American cultures but not in East Asian cultures (Chen, Kim, Sherman, & Hashimoto, 2015).

Thus, two key factors seem to be important in successful support transactions in East Asian cultures. One is social reliance in the sense of co-problem-solving. The feeling of being valued and cared for may be communicated via close

others' efforts to be directly involved in problem solving rather than expression of positive caring feelings per se (Chen et al., 2012; Fu & Markus, 2014). For instance, "controlling" parenting is more common in Asian American than European American cultural contexts (Fu & Markus, 2014). Moreover, controlling parenting is viewed more positively among Asian American students because, unlike among European Americans, it is typically accompanied by co-problem-solving (e.g., working together and advice-giving) and thus increases the sense of interdependence (Fu & Markus, 2014).

The other factor is close others' intimate awareness of one's affairs in life, rather than respect for privacy and independence, and their willingness to help without being asked to help. In East Asian cultures, where people feel that asserting their needs brings attention that undermines their roles within a relationship, the burden of initiating social support is more on close others than on potential support seekers. Thus, in East Asian cultures unsolicited social support brings greater benefits to recipients than does solicited support because it does not involve asserting one's needs (Mojaverian & Kim, 2013). In addition, experimental evidence has shown that social support brings positive psychological and biological (i.e., cortisol responses in acute stress situation) outcomes among East Asian Americans when social support is *implicitly* enacted by reminders of close others (Z. E. Taylor, Welch, Kim, & Sherman, 2007; see also Cai et al., 2013). Finally, support brings more positive outcomes among East Asians when they rely on close others' influence rather than asserting one's agency through independent decision making (Morling, Kitayama, & Miyamoto, 2003). For instance, compared to their European American counterparts, pregnant women in Japan rated social assurance (i.e., believing that close others can influence and help one's decisions) more highly as a coping method, and greater social assurance during the second trimester of the pregnancy predicted less distress and a more positive relationship with the newborn (Morling et al., 2003). Conversely, the effects of active support *seeking* are generally negative among East Asian Americans (Kim et al., 2006; S. E. Taylor et al., 2007). For example, in an experimental examination of support seeking, disclosing distress in letter writing exacerbated East Asians' reported stress and increased their cortisol levels (S. E. Taylor et al., 2007).

Cultural differences may exist in how potentially negative elements in relationships predict health outcomes. In the United States, ambivalent relationships characterized by a mixture of positive and negative feelings are associated with shorter telomeres, an indicator of cellular aging (Uchino et al., 2012). Also, a recent meta-analysis has shown that lower marital quality, characterized by low support and satisfaction and high strain and conflict, is associated with cardiovascular reactivity to marital conflict (Robles,

Slatcher, Trombello, & McGinn, 2014). However, in East Asian cultures, people appreciate the function of even somewhat unpleasant interactions (e.g., direct criticisms, interference with decision-making, social pressure) as important and constructive (e.g., Fu & Markus, 2014). Thus, the well-established link between strained or ambivalent family relationships and poor health may not hold in East Asian and East Asian American cultures. Empirical evidence for cultural differences in how negative relationship processes impact physical health outcomes has been rare. But one study examined cultural differences in the associations between characteristics of family relationship and proinflammatory cytokines interleukin-6 (IL-6), a biomarker of inflammation implicated in chronic diseases such as diabetes and heart disease (Chiang, Saphire-Bernstein, Kim, Sherman, & Taylor, 2013). Its results showed that a greater level of perceived social strain in the family (e.g., being often criticized and facing too many demands from parents) predicted higher levels of IL-6 among European American college students but not among Asian American college students. This interactive pattern held consistently within close friendships as well. Of course, this does not suggest that ill-intentioned, abusive interactions are adaptive. Rather, it indicates that social strain to achieve shared goals does not necessarily signal problematic relationships in East Asian cultures. These findings highlight that the very construct of relationship quality, and its implications for health, may vary by culture.

Family Relationships and Health in Latino Cultures

Family relationships are also at the core of social life among Latinos. Research on family relationships in Latinos has documented Latinos' strong attachment toward family, the social support derived from family, and the priority placed on active participation in routine family celebrations (e.g., birthdays, baptisms; Keefe, Padilla, & Carlos, 1979; Triandis, Marin, Betancourt, Lisansky, & Chang, 1982). In contrast to the *harmony collectivism* of East Asian culture, Latino *convivial collectivism* emphasizes warmth and expressivity in one's family and close relationships. Successful support transactions in this context involve active engagement and response in both support-seeking and support-giving behaviors as a means of affirming relationship bonds. Increasingly, empirical evidence has linked features of Latino *convivial collectivism* with many favorable relationship and health outcomes (Calderón-Tena et al., 2011; Campos, Rojas Perez, & Guardino, 2016; Campos et al., 2008, 2014; Lopez et al., 2004).

The feature of Latino culture that is most relevant to Latino cultural representations of family relationships is *familism* (also termed familialism or familismo). High familism is indicated by valuing interconnectedness among

family members, preferring family members as a first source of social support, feeling a sense of obligation to family, taking family into account when making important decisions, and willingly subordinating individual preferences for the benefit of family (e.g., Sabogal et al., 1987). The emphasis that Latino culture places on positive emotion as a means of affirming interdependent bonds is particularly important in family relationships; frequent, face-to-face, emotionally positive, social interaction among family members is a core element of this cultural ideal (Keefe et al., 1979; Triandis et al., 1982).

Current evidence has indicated that familism values increase the importance of the role that family relationships play in health and may operate as both a mediator and a moderator variable. Campos and colleagues (2014) found that higher familism in young adults indirectly predicted higher psychological health via a pathway through two relationship processes: higher closeness with family members and higher perceptions of social support. As expected from their specific blend of cultural collectivism, Latinos were highest on familism. Nonetheless, the paths from familism to support did not differ among Americans of Latino, European or Asian background, suggesting that familism is equally beneficial but less prevalent among non-Latinos. Another study of an older adult Latino sample found that familism was associated with lower depression symptoms (Chavez-Korell, Benson-Florez, Delgado Rendon, & Farias, 2014). Similarly, family warmth has been associated with reduced risk of schizophrenia relapse in Latinos but not in European Americans (Lopez et al., 2004). Overall, these findings are consistent with theorizing that familism may create contexts that make it easier for Latinos to perceive, obtain, and benefit from social support, which in turn benefits relationships and health.

Studies that have examined social support processes in Latinos without directly measuring specific cultural values have also indicated that social support and its benefits are elevated in Latinos. For example, Latinos have reported higher levels of both perceived and received support than have other U.S. comparison groups (e.g., Almeida, Molnar, Kawachi, & Subramanian, 2009; Kaniasty & Norris, 2000). In the Kaniasty and Norris (2000) study, Latinos reported high levels of comfort with social support seeking in emergency and nonemergency situations, a pattern that differs from that found in studies of East Asian samples. A cultural environment that emphasizes social support has been suggested to play an important role in physical health, including the surprising longevity of Latinos (e.g., Ruiz, Steffen, & Smith, 2013) and healthy aging of older Latinos living in majority Latino neighborhoods (e.g., Eschbach, Ostir, Patel, Markides, & Goodwin, 2004). Despite this growing evidence, laboratory studies of social support seeking and receiving in Latinos that are comparable to the literature on East Asians still need to be generated to better understand

social support processes and the association of those processes with health in Latinos.

Despite the predominantly favorable effects of familism values, there is also indication that the centrality of family can also adversely impact Latino health when relationships fail to meet cultural ideals of closeness and positivity. In contrast to studies of East Asians that indicate that health may be less impaired by relationship strains (e.g., Chiang et al., 2013), familism has been linked with increased vulnerability to psychological distress when parent-child discord is high (e.g., Hernández, Ramírez García, & Flynn, 2010). High familism values have also been associated with attempted suicide in young Latinas experiencing high mother-daughter conflict (Zayas & Pilat, 2008). When financial strains are high or people are seriously ill, it is possible that familism values may require sacrifice that overwhelms individual resources to meet obligations (Calzada, Tamis-LeMonda, & Yoshikawa, 2013; Fuligni et al., 2009). Despite this, the reward derived from meeting one's obligations to family may still be health-protective. In the Fuligni et al. (2009) study, time spent by Latino adolescents assisting their families at home was linked with elevated proinflammatory cytokine activity but with an important moderator—adolescents who derived a sense of role fulfillment from the family support they provided had lower levels of that activity.

Altogether, Latino *convivial collectivism* appears to heighten reliance on family relationships as a source of support and amplifies its relevance for health. In contrast to studies of East Asians, studies of Latinos have found that they are comfortable with support seeking, particularly from family (e.g., Chavez-Korell et al., 2014; Kaniasty & Norris, 2000). Studies have also shown that familism can set the stage for positive relationship processes that have indirect or downstream benefits for health. For example, familism in Latinos has been associated with reduced conflict between parents, family member prosocial behavior, and satisfying romantic relationships (e.g., Calderón-Tena et al., 2011; Campos et al., 2016; Z. E. Taylor, Larsen-Rife, Conger, & Widaman, 2012). Positive relational processes are linked to healthy and long lives, and the role of Latino culture in facilitating closeness, support, and prosocial behavior is likely important for Latino health, an intriguing possibility that has long been theorized but little tested (Ruiz et al., 2013).

Although there has been much recent progress on this topic, there are still many ways in which the literature on culture, relationships, and health may grow. First, much of the empirical studies tend to examine relationships as a broad and general construct. However, there may be many different moderators of current findings. A literature on specific characteristics of relationships, whether hierarchical or a relationship between parent-child, romantic partners, or friends, as well as the developmental stage of those

involved needs to be better developed. Second, the empirical emphasis in this area tends to be on identifying social and psychological mechanisms used during relatively acute distress responses. Unfortunately, this means that the generalizability of survey- or lab-based findings to long-term physical health has not been sufficiently tested. Going forward, researchers should be mindful of these limitations of the current literature, and future research should seek to address them.

Beyond East Asian and Latino Examples: Relationships in Other Cultures

The example of East Asians and Latinos highlights the importance of considering distinct blends of collectivistic orientation for understanding family and other close relationships and their implications for health. However, a full understanding of cultural diversity requires incorporating other understudied national cultures as well as many forms of nonnational or ethnic cultures, such as social class and religion (A. B. Cohen, 2009). The following section discusses some of the relevant findings. The intention here is not to fully cover the topics but rather to introduce a sample of existing findings as a way to inspire researchers to expand the database.

At the moment, relatively little systematic empirical research has examined social relationships and their health implications in cultures other than East Asian and Latino cultures. However, a few published studies have found evidence of novel and interesting patterns that have not yet been incorporated into the field's broader understanding of cultural variation. For example, at least one study has found that communal values are associated with more positive infant birth outcomes in African American mothers (Abdou et al., 2010), a U.S. group whose form of collectivism remains understudied by relationship and health researchers. Southern Europe has also been characterized by a unique blend of primary cultural constructs. One study has investigated social support use among Greek and British participants (Kafetsios & Nezlek, 2012). In this study, Greeks reported lower perceived social support and less positive or more negative affect in daily social interactions than did the British, a pattern similar to that observed in Asians. However, the association of positive affect with support perceptions was stronger among Greeks than British. Greeks, who experienced positive affect less commonly than did the British, may have perceived greater support in response to relatively unusual interactions with positive affect. A few studies conducted in eastern Europe highlight yet another way to understand the link between close relationships and health. A study in which Romanians reported their stress coping strategies and coping outcomes found that coping strategies that U.S. researchers have typically viewed as maladaptive (e.g., venting, complaining) were associated

with positive psychological outcomes among Romanians (Lawrie, Mojaverian, & Kim, 2017). In Russia, practical interdependence, which is akin to East Asian pragmatism, manifests in behaviors such as problem-focused advice-giving (Chentsova-Dutton & Vaughn, 2012). These examples underscore the necessity of documenting relational processes in a wider range of national and regional cultures.

Shifting to nonregional forms of culture, social class and religion stand out as two primary sources of culture that have implications for relationships and health. Much research has found a linear association between physical and psychological health and socioeconomic status (SES; e.g., Gallo & Matthews, 2003; Miller et al., 2009). These studies have tended to focus on disparities in various types of resources (e.g., reserve capacity model; Gallo & Matthews, 2003), but few such studies have considered cultural psychological mechanisms that may link relationships and health. Existing research has shown that lower SES people tend to have more interdependent views of the self relative to higher SES people (Stephens, Hamedani, & Destin, 2014). Consequently, lower SES people tend to derive greater meaning in life from parental caregiving of their children than do higher SES people (Kushlev, Dunn, & Ashton-James, 2012). Moreover, social relationships are more important resources for lower SES people than for higher SES people (Stephens, Markus, & Townsend, 2007). Support from close others, especially family, reduces inflammatory reactivity more for people from lower SES background than from higher SES background (e.g., John-Henderson, Stellar, Mendoza-Denton, & Francis, 2015). This suggests that supportive social relationships, a social resource that may be more scarce in low SES contexts (Gallo & Matthews, 2003), may maximally benefit low SES individuals when available.

Religion, religious affiliations, and individual religiosity comprise another form of culture that also impacts how people conceptualize family and other close relationships.¹ Being religious and part of a religious community is a buffer in the face of distress and stressful life events and is associated with lower blood pressure and lower rates of coronary disease, suicide, and mortality (Chida, Steptoe, & Powell, 2009; Larson et al., 1989; see Masters & Hooker, 2013, for a review). One function of religion is thought to be ingroup cohesion and solidarity that expands the notion of family to others of the same religious community (Wilson, 2002). The benefits of religion, at least in part, may result from increased social networks that serve as a surrogate or complement to one's family. Indeed, the mental health

¹ Spirituality is a related concept, but studies have found that interpersonal styles and goals associated with these two constructs are different (e.g., Jordan, Masters, Hooker, Ruiz, & Smith, 2014). In this review, we focus on the literature on religion, because it shares more features with culture, with shared rituals and an established belief system.

benefits of religion exist through increased availability of social support (Salsman, Brown, Brechting, & Carlson, 2005).

Still another separate literature has focused on the processes that come into play when distinct cultures interact. Acculturation, the process of adapting to a new cultural context, changes both relationships and health (Flores, Tschann, VanOss Marin, & Pantoja, 2004; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005), but little is known about how these processes are linked together. When relationships form between people of different cultures, these experiences may influence health but the experiences and their potential links to health are poorly understood. Over time, cultural contact results in mixing that forms new cultural blends. This is exemplified by the growing number of people who identify as bicultural or multicultural. How relationships impact health in these contexts is a topic about which little is known but is of growing research importance.

Existing evidence has clearly shown that all forms of culture—whether national, ethnic, social class, or religion—have implications for close relationships. Yet, research documenting health differences based on these social groupings have rarely examined psychological processes involved in culture or relationships, two very important factors impacting health. A more systematic examination of relevant psychological processes across a wide variety of cultures is needed to generate a better understanding of the diverse means by which humans manage health through their important relationships.

Recommendations for Future Research and Health Professions

It is clear that culture shapes what adaptive family and other close relationships look like, how relationships serve as a source of social integration and support, and how relationship interactions impact health and well-being. Moreover, it is clear that culture operates at multiple levels, sometimes mediating, sometimes moderating, and sometimes setting the stage for psychological processes that humans share in common. Cultural diversity is simply more varied, multifaceted, and complex than is commonly understood. For research in this area to develop in productive ways, researchers need to embrace this complexity. The following recommendations are made to help push this goal forward. Some may be familiar to practitioners but not to researchers; others are already essential research tools that are less familiar to practitioners. Like the topics of this article, integrating what has been separate is crucial to progress.

The first recommendation is for researchers to systematically incorporate culture into their work. Better understanding of the link between relationships and health across cultural groups other than one's own requires examination of the potential influence of culture (Campos, 2015). The

adoption of *cultural humility*, which entails acknowledgment that one's cultural knowledge is limited and that cultural learning is an ongoing process (Hunt, 2005), may aid such examinations. *Community-based participatory research* (CBPR), a method for directly engaging with people affected by a focal health issue as full partners throughout all stages of research (Israel, Eng, Schulz, & Parker, 2005), can also help researchers with this goal. For example, CBPR methods have been used to shed new light on the pattern whereby U.S. acculturation is associated with more stress and less positive meanings ascribed to childbearing among Latinas (Dunkel Schetter et al., 2013). One area ripe for study via this approach is the meaning of high-quality relationships, which may not fit the presumptive definition of high levels of warmth and support; attendant health implications may depend on relationship expectations and specific meanings.

The second recommendation is for researchers to expand cultural investigations of how relational processes impact health beyond social support. This review focused on social support because it is the most studied aspect of relationships with implications for culture and health, but relationship processes extend beyond social support. Other relationship processes with health implications, such as relationship formation and dissolution; conflict resolution; and the ways that family, partners, and friends are integrated into one's network, need further understanding (Robles et al., 2014; Sbarra, Law, & Portley, 2011). For example, social integration is increasingly recognized as a key factor that predicts length of life (e.g., Holt-Lunstad & Smith, 2012). Collectivistic cultures, with their low relational mobility, may help people to draw from their family of origin relationships to maintain high levels of health-protective social integration. Conversely, however, health may suffer harm from damaging relationships that one is born into and cannot easily dissolve. These possibilities should be examined across diverse cultures.

The third recommendation is that professional health services and practitioners be culturally responsive to variation in everyday relationship processes. Responsiveness to cultural expectations about social relationships is crucial to successful patient-provider communication, diagnosis, and treatment. One study has shown that well-established cultural differences in people's willingness to seek help from professional health services between European Americans and East Asians (Japanese) is mediated by willingness to seek social support from one's own social network (Mojaverian, Hashimoto, & Kim, 2013). This finding suggests that people may perceive health professionals as an extension of their social network and prefer to engage with them like they engage with family members and close others. Incorporating the knowledge about how people manage their everyday relationships into the professional health service setting is likely to promote high-quality care char-

acterized by stronger therapeutic alliances and more effective clinical decision-making.

Culture, relationships, and health are universal elements of human social life. A better understanding of culture that is more comprehensive, nuanced, and inclusive of the great diversity of human relationship experience is likely to yield important new insights about the role of relationships in health. Achieving this goal requires greater acknowledgment of the cultural underpinning of current understanding of relationships and health and resultant systematic inclusion of diverse perspectives. Together, these steps can move the field toward integrating the study of culture into relationships and health.

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