Published in final edited form as:
Health Educ Behav. 2009 October ; 36(5 0): 55S–70S. doi:10.1177/1090198109335338.

Theorizing Social Context: Rethinking Behavioral Theory

Nancy J. Burke, PhD, **Galen Joseph, PhD**, **Rena J. Pasick, DrPH**, and **Judith C. Barker, PhD**

Abstract

Major behavioral theories focus on proximal influences on behavior that are considered to be predominantly cognitive characteristics of the individual largely uninfluenced by social context. Social ecological models integrate multiple levels of influence on health behavior and are noted for emphasizing the interdependence of environmental settings and life domains. This theory-based article explains how social context is conceptualized in the social sciences and how the social science conceptualization differs from and can broaden the analytic approach to health behavior. The authors use qualitative data from the "Behavioral Constructs and Culture in Cancer Screening" study to illustrate our conceptualization of social context. We conclude that the incorporation into health behavior theory of a multidimensional socio-culturally oriented, theoretical approach to social context is critical to understand and redress health disparities in multicultural societies like that in the United States.

Keywords

Social context; culture; health behavior theory; social science theory

> Many of these [behavioral] theories end up blaming the victim for their own circumstances. "What, you can't plan? What, you can't reason?" You know. "You can't think? You can't believe? You don't have knowledge? …" We need to make explicit the assumptions that guide these theories and the limitations that underlie the theories
>
> Study Key Informant 3

Over the past decade, the importance of social context to understanding health behavior and decision-making has been increasingly recognized in public health research (Emmons 2000; Frohlich, Corin, & Potvin 2001; McKinlay 1995; Perry, Thompson, and Fowkes 2002; Revenson & Pranikoff 2005; Sorensen et al. 2003; Susser & Susser 1996; Williams 1995). Two streams of research have addressed the role of social context in health behavior: social psychological models and social ecological models. This article contributes to the emerging public health literature by suggesting a third approach to social context. Social context as used and theorized in the social science disciplines of anthropology and sociology, should be integrated with emerging social cognitive and ecological models for a more complete understanding of health behavior. We show how and why social context broadly conceived offers significant opportunities for deeper understanding of behavior as well as dynamics that likely figure importantly in health disparities.

In most social psychological theories of health behavior, social context has been consistently relegated to a relatively minor influence on individual behavior and health outcomes. While behavioral science seeks to understand, explain, and often change human behavior through the adoption of healthier lifestyles, behaviors, and attitudes, the theories employed have an individual, cognitive focus, largely abstracted from social context (Frohlich et al., 2001;

Singer & Weeks, 1996; Williams, 1995). Based in these theories, much prevention research places emphasis on cognitive and motivational variables including how individuals interpret behavioral information, how they value that information, and how capable they feel to use the information (Bandura, 1984; Krumeich, Weijts, Reddy, & Meijer-Weitz, 2001; Singer & Weeks, 1996). Social, organizational, historical, political, and cultural influences upon individual behavior are, at best, relegated to the position of background variables, acknowledged only insofar as they affect beliefs that are theorized to be a dominant influence. Importantly, when they are acknowledged, these organizational, political, and so on, associations are mainly framed as unidirectional, the individual being the recipient or object of unchanging external forces.

Over the past decade, several critiques of behavioral models have attempted to move the focus of health promotion research and practice beyond the realm of individual behavior by demonstrating the inextricable ways that context, in a variety of forms, is integral to health and health behavior outcomes. These efforts have generated social ecological models incorporating social context (Berkman & Glass, 2000; Emmons, 2000; Krieger, 2005; Kreiger & Davey Smith, 2001; Stockols, 1992); conceptualizing social context as both modifying conditions and mediating mechanisms (Sorensen et al. 2003); and re-defining social contexts as risk regulators[i] (Glass & McAtee 2006). As one critic summarized,

> "There has been a gradual shift away from explaining health related behavior simply in terms of 'health beliefs' (i.e., health belief models etc.) toward attempting to understand the lay person's actions in terms of their own logic, knowledge and beliefs which are grounded in the context of people's daily lives"
>
> (Williams 1995:580).

This article elaborates a theoretical approach to "social context" that draws on the social sciences of anthropology and sociology to understand the multiple dimensions of social and cultural phenomena in daily life as they relate to the health behavior of underserved[ii] women. We define social context as the sociocultural forces that shape people's day-to-day experiences and that directly and indirectly affect health and behavior (Pasick & Burke, 2008). These forces include historical, political, legal structures and processes (e.g. colonialism and migration), organizations and institutions (e.g. schools, clinics, and community), and individual and personal trajectories (e.g. family, interpersonal relationships). Notably, these forces are co-constituitive, meaning they are formed in relation to and by each other and often influence people in ways of which they are not consciously aware. In the following, we explain the theoretical basis for this definition of social context, and detail how it is always situationally dependent.

The theoretical approach we propose here evolved from a combination of social science literature and our findings from an inductive, qualitative study of the appropriateness of several behavioral theory constructs for understanding the practice of getting a mammogram among US Filipina and Latina women. Elsewhere we detail problems with the use of health behavior theory in the study of mammography screening in underserved populations (Pasick & Burke 2008). In this volume, we focus on describing the study – "*Behavioral Constructs and Culture in Cancer Screening*" (R01 CA81816, Pasick, Principal Investigator), known as the "3C's" project – and its findings in detail. Four other articles in this volume detail study methods and findings: (a) the study overview, methods, and major findings (Pasick, Burke,

[i]"Risk regulator" is a class for variables that capture aspects of social structure that influence individual action. It is defined as "a relatively stable feature of a particular patch of the social and built environments, residing at levels of organization above the individual … but below larger-scale macro-social levels" (Glass & McAtee, 2006, p. 10).

[ii]"Underserved" here refers to poor, underemployed, undereducated, and sometimes limited English proficient women essentially women who are not adequately cared for by the current structure of health care in the United States.

et al., 2009); accompanied by in-depth analyses of three major domains of social context that emerged from our data – (b) social capital (Burke et al.2009); c) transculturation/ transmigration (Joseph, Burke, Tuason, Barker, & Pasick, 2009); and (d) relational culture (Pasick, Barker, et al., 2009). These other reports examine the implications of our theoretical perspective on social context for specific behavioral theory constructs. In other words, our 3C's study explores a more contextualized approach to health behavior (specifically, use of mammography), and draws conclusions about the validity of traditional behavioral constructs from this perspective.

The purpose of the present article is to set the stage for those articles by: (a) introducing readers to the social science theory behind our data analyses, and (b) contrasting it with dominant forms of analysis in health behavior research (health behavior theory and SE models). In the sections that follow, our data in the form of exemplary quotes serve as brief examples that illustrate various aspects of the concept of social context. We discuss some assumptions made by social psychological theories, assumptions that limit the theory's value with regard to behavior in the context of diverse ethnic and underserved individuals and groups. Next, we examine more closely social cognitive theory (SCT) and SE models which represent important advances that embed the individual in the context of her social and physical environments. We then address the theoretical influences behind our conceptualization of the relationship between the individual and social context, highlighting key ideas in social science theory such as individual agency and rational action. We conclude with a discussion of the implications of our conceptualization of social context for health promotion and practice.

BACKGROUND

Social Context and Health Behavior Theories

Health behavior theorists have made great strides in understanding cognitive processes and attitude development. Weinstein (1993) and others (Frohlich et al., 2001; Williams, 1995) have noted, however, that there is an abundance of empirical research utilizing the same healthbehavior theories without much innovation or change. At the same time, recognizingshortcomings of individual-level factors, many public health researchers have begun to return tothe field's ecological roots to reconsider the role of the environment in health behavior anddisease outcomes (Berkman & Glass, 2000; Emmons, 2000; Frohlich et al., 2001; Krieger, 1994; Krieger & Davey Smith, 2004; McLeroy, Bibeau, Steckler, & Glanz, 1988). As Glass and McAtleen state,

> The study of health behavior inisolation from the broader social and environmental context is incomplete, and has contributed todisappointing results from experiments in behavior change. The solution requires a shift inemphasis, a reorientation of theories and new methods
>
> (Glass & McAtleen, 2006, p. 15; see also Pasick & Burke, 2008; Pasick, Hiatt, & Paskett, 2004).

In addition to broadening the context addressed in research informed byhealth behavior theory (making it more "complete"), it is necessary to note the sociocultural and historical contexts in which these theories were developed (Kuhn 1970; Latour & Woolgar 1986)for these heavily influence the assumptions built into the theories and their associated limitations.

Assumptions Underlying Social Psychological Theories of Health Behavior

One key assumption informing health behavior theories is the standard or "norm" on which they are based: White, urban, middle-class Americans. The persistence of this assumed norm

is linked to the social, cultural and historical context of the practice of health behavior research and theory production: Until recently, leaders in the field of health behavior have been predominantly White, male, and middle class, and employed at prestigious educational or research institutions. Their social context and experience not only shaped their research and research questions but also dictated their choice of research study participants who have overwhelmingly been White, middle-class, young adults, predominantly college students (Ajzen 1991; Emmons 2000). The social context of urban, White, middle-class Americans has been well represented by health care providers, the health care system, and health behavior research more than has the social context of poor people, immigrants, rural populations, people of color, or national minorities. Minorities remain underrepresented among medical school faculty, admissions committees, students in research fields in medical curricula (Fang, Moy, Colburn, & Hurley, 2000; Hagey & MacKay, 2000; Puzan, 2003; Liu, 2005; Smedley, Butler, & Bristow, 2004). As a result, processes of exclusion and discrimination are reproduced in the U.S. healthcare system and in the structure of public health research including the theories guiding such research.

Studies of social and cultural aspects of "Whiteness" (as an identity or set of social and cultural processes associated with racial privilege) have shown that Whiteness often remains "unmarked", that is, an invisible and assumed norm, especially when White groups are demographically predominant in society (Frankenberg 1997). "Whiteness makes itself invisible precisely by asserting its normalcy" (Frankenberg 1997:6). Like other racial and cultural identities, Whiteness is not monolithic; its meanings are historically specific, socially constructed and inflected by class (Hartigan Jr 1999; Roediger 1991), gender (Frankenberg 1993), and geography or local practices (e.g. Dominguez 1986; Joseph 2000). In the case of health behavior research, the (unconscious and unintentional) assumed norms of White, urban, middle class Americans have obscured many aspects of social context including differences among women's health care options (on the basis of social, cultural, and structural barriers) and decision making processes and the complex relationships between intentions and behavior. The most influential health behavior theories are the health belief model (Becker 1974; Rosenstock 1966, 1974), the theory of reasoned action/theory of planned behavior (Azjen 1991; Ajzen & Fishbein 1980), the transtheoretical model (Prochaska & DiClemente 1992), and social cognitive theory (Bandura, 1986, 2000; Glanz, Lewis, Rimer, 2002). Using similar constructs, these theories all seek to explain health behavior through differential emphasis on one construct or another (Redding, Rossi, Rossi, Velicer, & Prochaska, 2000, p. 181). The foundation underlying these approaches is the belief that behavior is ultimately under the individual's control and conscious awareness. Thus, behavior change comes about via various forms of self-regulation (Frohlich et al. 2001) – cognition (Ajzen & Fishbein, 1980; Becker, 1974), confidence in the ability to act (Bandura 1986, 1988, 1991, 1992), strength of one's intention (Ajzen & Fishbein 1980), or volition and self-control (Baumeister & Healtherton 1996). This approach views behavior as individually defined and independently produced, as uninfluenced by the social relations embedded in the rules, values, and resources of social structures and contexts. The only context that is relevant for health behavior, in these theories, is the most immediate context (i.e., time and place).

The Individual in Context: Social Cognitive Theory

Of all the health behavior theories, Albert Bandura's SCT represents a major advance in the field because it explicitly goes beyond individual factors in health behavior change to include environmental and social factors (Bandura 1986, 1997, 2002; Redding 2000, p.184). Thus, SCT serves as the best psychological theory against which to examine social science theories to understanding context and its influence on behavior.

SCT seeks to explain human behavior in terms of a triadic, reciprocal model in which a person's behavior, personal factors (including cognitions and personal characteristics), and the environment in which the behavior is performed interact and influence each other (Bandura 1986, 1997; Glanz et al. 2002, pp. 165, 168). The dynamic nature of this framework, with its recognition of the individual as agent in control of his or her own life is noteworthy for moving health behavior theory beyond mechanistic views of human behavior (Bandura 1997, 2002; Glanz et al. 2002). Most empirical investigations and measures originating in SCT, however, overlook this dynamic, more complex formulation in favor of universal and greatly simplified measures of attributes that are devoid of social or cultural input or environmental influence (i.e., a measure for self-efficacy is "How confident are you that you can get a mammogram every year?"). In SCT, social context is considered as it relates to attitude development and assessment (Terry & Hogg, 2000), and is equated with social environment, largely conditioned by social and subjective norms, a network of social influences, that "aid, retard, or undermine efforts at personal change" (Bandura 1994, p. 43). Normative influences within the social environment regulate behavior through social and self-sanctions (Bandura 1986) including social approval, rewards, and censure or other punitive consequences. In a volume addressing the relationship between attitudes, behavior, and social context, Terry and Hogg (2000) clearly delineate the limits of the SCT concept of social context:

> People's attitudes are developed and expressed as behaviors in a context that is social; it contains other people who are actually present or who are invisibly present in the social norms that define social groups to which we do or do not belong (2000: 2).

Thus, social environment is important, in part, because it provides models for and influences on behavior (Baronowski et al. 2002). However, social environment – not exclusively a techno-built environment, residential site or locale – "is not simply a fixed entity that inevitably impinges upon individuals. People select, construct, and negotiate environments partly on the basis of their self-beliefs of efficacy" (Bandura 1994: 49). Following the logic of this theory, where efficacy is construed as representing individual knowledge evaluation and action, individuals armed with necessary information and the belief that they can act on this information can restructure their lives to avoid detrimental outcomes. And they can select beneficial social environments that promote the desired lifestyle or behavior (Bandura 1994:49). This conception of social context as a normative social environment that enables free choice within the limits of self-efficacy is narrower than the multidimensional understanding and operationalization of social context we advocate.

Social Ecological Models

SE models integrate multiple levels of influence found in intrapersonal, interpersonal, institutional, community and public policy processes (Stokols 1996). The term ecology refers to the study of the relationships between organisms and their environments; SE models are noted for emphasizing the "interdependence of environmental conditions within particular settings and the interconnections between multiple settings and life domains" (Stokols 1996, p. 286). This interdependence is similar to Bandura's concept of reciprocal determinism, which also notes the mutual influence of behavior, personal and environmental factors (Bandura 1986; Sallis & Owen 2008). SE models are based on the assumption that health is influenced by multiple facets of physical and social environments; that environments themselves are multidimensional (e.g. social or physical, actual or perceived); that human-environment interactions can be described at various separate levels, such as individual, family, organizational, or population level; and that there is reciprocal feedback across different levels between groups of people (Sallis & Owen 2008; Stokols 1996).

The promise of SE models is their ability to address multiple levels of social and physical environments, and to intervene, focusing on different targets, at these different levels – individual behavior at the intrapersonal and interpersonal levels, organizational change at the community and institutional level, and policy change at the systems level (Best et al. 2003; Emmons 2000). *Healthy People 2010* (US Department of Health and Human Services, 2000) and the Institute of Medicine's report on promoting healthy behavior (Smedley & Syme 2000) note the need for multilevel interventions and there is increasing evidence that multi-leveled approaches informed by SE models are bringing about improvements in some aspects of population health (Emmons 2000; Sallis & Owen 2008). A challenge to the SE models, however, is their reliance on preexisting health behavior theories and constructs for intervention at each level.

THEORIZING HEALTH BEHAVIOR IN SOCIAL CONTEXT

Theory developed over the past 20–30 years in the disciplines of sociology and anthropology can further broaden our understanding of context with many implications for understanding health behavior. Next we turn to social science theories of the relationship of the individual to social structure. These theories and the qualitative data collected in our study – inserted as sidebars throughout this article, and taking the form of illustrative quotes – show (a) that the relationship between an individual and her social context is complex, shaped and constituted by social, cultural, economic, political, legal, historical and structural forces; (b) that this relationship is multi-directional, co-constitutive, and constantly in formation; and (c) that the multi-layered influences in which the individual is embedded are often beyond the level of individual consciousness.

> Int: When you decided to stop taking the medicine, did you talk to someone?
>
> SP: No, I decided myself… I couldn't stand that medication anymore. I thought, well, they had already operated … but they didn't explain to me either. If they explained it, I didn't understand. Why did I have to take that medicine? When I left the hospital, they gave me my medicines and that was it. They said to take it, but they didn't tell me what it was for. I am very sure they didn't tell me what it was for. (L13)
>
> This interview with a Latina immigrant illustrates the complex interplay of her experience interacting with medical providers in her home country and the US combined with cultural norms of respect for authority (e.g. you don't ask questions) and the limitations of the US healthcare system (disjointed care, lack of communication). Thus, the behavior of taking or not taking one's medication, embedded in this wider context, is a social practice.

Culture and Context

Culture governs and yet is influenced by social context. We understand culture (in an anthropological sense) as the patterned process of people making sense of their world and the (conscious and unconscious) assumptions, expectations, knowledges, and practices they call upon to do so. The term *patterned* indicates that culture is not random. Instead there are consistencies within culture that are at the same time flexible and situationally responsive; the term *process* indicates that culture is not bounded or static but rather dynamic, fluid, constantly being shaped and reshaped. People bring culture into being as they go about making their world – making the structures, institutions, rituals and beliefs that reflect and (re)produce individual and collective sense-making activities (Bourdieu 1990; Geertz 1973). Culture is not distinct from or equivalent to religion, politics, or any other social institution such as economics or kinship; rather it is an integral part of all of them—forming them and being formed by them according to situation and circumstance. Thus, culture is a dynamic

process that changes over time and across space, whether in contact with or in isolation from other groups, and is not a discrete entity with a material presence, fixed attributes or clear boundaries. It is the outcome of the interactions, feelings, and thoughts of many people and their diverse, often overlapping, sometimes contradictory, attempts to make sense of their world and live in it. This view of culture differs from the discrete, bounded, identifiable categories taken up in social psychology (Triandis 1989). For example, rather than typifying some cultures as individualist or collectivist, simple or complex, this more flexible view of culture recognizes a range of acceptable but different orientations within a given cultural group, some of which become more or less emphasized in different situations or contexts. Thus, an analysis of behavior in social context requires an understanding of the dynamic nature of culture and the processes by which it is brought into being.

The concept of social practice, as developed by sociologist Pierre Bourdieu (1990) helps us to understand behavior in social and cultural context—that is, within the wider structures and patterns of social life (Jenkins 2002; Williams 1995). Our goal is to provide a theoretical approach to conceptualize the influence of wider structures and patterns (i.e., context) on individual behavior. The concept of social practice reflects the understanding that no behavior occurs in isolation from its immediate and broad context; the term *social practice* indicates that a health behavior is not only a product of context broadly defined, but also contributes to and alters that context. This perspective marks an epistemological shift from, and broadens the focus of, the traditional objectives of behavioral science research. That is, we view behavior in relationship to the surrounding expectations, social structures, and resources rather than viewing behavior as solely under individual control. We posit that these behaviors simultaneously constitute, and are constituted by the rules, relationships, expectations, and resources of social structures. Therefore, analyses of behavior require theory that addresses the multiple interacting dimensions of social structures and people's awareness of, conformity with, and resistance to those structures.

> Int: "Okay, and how does this [core values of *kapwa* and *loob*], influence or affect their [Filipino young adults'] behavior, their decisions?"
>
> KI: " Yyyyyyyyes, well that's what I found out, that even though they no longer speak Tagalog, when they hear the concept and it's explained to them they will say 'ohhhhhhh so that's what it is'. They've always known it intuitively because that's what, how they were raised. And so they now have the linguistic part of it, to explain what they have always known and what they have always felt."(KI04)
>
> A Filipino sociologist explained how awareness and understanding of core cultural values remained under the surface, outside of conscious awareness as embodied experiences; not fully understood until discussed and given names.

For Bourdieu, conscious and deliberate intentions are necessary but insufficient explanations for behavior (Jenkins 2002). Bourdieu's concept of *habitus,* central to his theory of practice, serves as his critical response to the idea that conscious and deliberate intentions alone are sufficient explanation of why people do what they do: *Habitus* is "embodied history, internalized as second nature…" (Bourdieu 1990: 56). It reflects "the presence of the past" in how people deal with their current conditions and in how they anticipate the future and it accounts for how social conditions are reproduced. The active presence of these past experiences – strongly influenced by class (i.e. socioeconomic) formations in Bourdieu's theory – inform perceptions, thought and action, albeit unconsciously (Bourdieu 1990: 54). In Bourdieu's theory of *habitus*, "unconscious" means an embodied awareness that influences practice yet is outside conscious awareness or below the threshold of consciousness. This is distinct from a psychological or Freudian concept of the unconscious or subconscious in that for Bourdieu, the unconscious is a product of social forces rather than individual psychology. *Habitus* exists only in and through the practices of individuals

and their interaction with each other and their environment, thus *habitus* "is not just *manifest* in behavior, it is an integral *part* of it (and vice versa)" (Jenkins 2002: 75, emphasis in original). *Habitus* "shows that routine behavior is the product, not simply of biological or psychological motivation, but also of larger social, cultural, and historical forces. In doing so, it shows how individual behaviors relate to social rules and morality" (Crossley 2004: 239). Bourdieu conceptualizes the relationship between individual agency and social structures as continually interconnected and co-constitutive, rather than discrete and separable. In other words, *habitus* is a dialectical product of the social structure, which informs the practices of individuals, which in turn constitute the social structure. Here, then, is a key point of departure from SE models which see behaviors as occurring at various fixed levels that are reciprocally influential but not flexibly and ineradicably co-constitutive. A critical element of Bourdieu's concept of *habitus* is that its influences are outside conscious awareness, and therefore are *observable* in the practices of individuals but *not reportable* by them in the form of conscious attitudes or beliefs. "*Habitus* provides individuals with class-dependent, pre-disposed, yet seemingly 'naturalized' ways of thinking, feeling, acting, and classifying the social world and their location within it" (Williams 1995: 586). Thus, people are not consciously aware of all the influences on their behavior. In Bourdieu's theory, practice emerges from the relationship between external constraints, such as economic and socio-political conditions, and predispositions or unconscious internalizations of social constraints (Bourdieu 1990:50). Such pre-dispositions are naturalized, comprise "common sense," are so obvious and feel so right and proper within a given cultural or social context that members of the group cannot further explain them; they just are. Social "rules" that govern etiquette and morality comprise examples of naturalized pre-dispositions. Practices of daily life, therefore, emerge from the individual's relationship with social structures and their internalized unconscious (system of) pre-dispositions – from the economic, social and other cultural processes in conjunction with "common sense."

Anthony Giddens (1984) also tackles the relationship of individuals to the social structure in his theory of structuration, but in a slightly different way. He argues that individuals engage in their historically and spatially rooted environments in a reciprocal manner: Individuals pursue goals within the constraints, opportunities and resources available in their local environments and by doing so re-create somewhat imperfectly the social structures of these local environments (Giddens 1984; Glass & McAtee 2006). That is, because of the variability of practices, social structures are reproduced with differences rather than identically, leading to social change. For Giddens (1984, p. 25), "structure is not 'external to individuals': as memory traces and as instantiated in social practices, it is in a sense more 'internal' than exterior to their activities". Thus he differs from Bourdieu in that he sees the individual as more autonomous, and less constrained by social and class structures. Giddens views individuals as productive agents creating the social structure through their practices (Giddens 1984; Frohlich et al. 2001), whereas Bourdieu, through his concept of *habitus*, gives more weight to class and social structure as determinants of perception and practice (Bourdieu 1977; Frohlich et al. 2001).

Although conceptualizing the role of the individual and her agency in relationship to social structure differently, both Giddens and Bourdieu are useful in our elaboration of "social context" as each attends to the powerful but unconscious or out of conscious awareness influences of social structures. And each views the separation of structure and agency as an abstract heuristic exercise rather than a representation of reality.

Rationality versus Reality

In his more recent work, Bandura also "rejects a dualism between personal agency and a disembodied social structure" (2002, p. 8). However, in practice, he constructs a

"multicausal model" (2002: 8) that tends to remain focused on measuring self-efficacy as a predictor of behavior change in terms of "personal agency exercised individually; proxy agency in which people secure desired outcomes by influencing others to act on their behalf; and collective agency in which people act in concert to shape their future." (2002 abstract) Thus, in his SCT, Bandura envisions a world of crosscultural and intracultural variation, but one in which individuals — whether acting alone, on behalf of, or in concert with others— have varying degrees of a measurable efficacy to achieve their goals. As an example, he argues that

> the higher the people's perceived efficacy to fulfill educational requirements and occupational roles the wider the career options they seriously consider pursuing, the greater the interest they have in them, the better they prepare themselves educationally for different occupational careers…People simply eliminate from consideration entire classes of occupations they believe to be beyond their capabilities
>
> (Bandura 2002: 9)

In this formulation, individual agency and self-efficacy are separate from social structures, and social context as a "structuring structure" (Bourdieu 1990:53) drops out of frame. Unlike Bourdieu's and Giddens' theories, Bandura's social structure is not internalized and normalized in the individual's unconscious. In contrast to Bandura's formulation, we argue that a person may not 'simply eliminate' various options from consideration (Bandura 2002: 9) because of a lack of self efficacy or agency, but rather a person may choose quite rationally within the constraints that she unconsciously recognizes as constituting her "sense of reality" (Bourdieu 1990: 60), her social world, her knowledge of social opportunities and social costs. This contrasts with the "rational actor theory" postulation underlying SCT that "rational action can have no other principle than the intention of rationality" (Williams 1995), with rational choice being clearly perceived and fully articulated. Instead, we see one's rational intention or sense of efficacy as a product of what Bourdieu calls this "sense of reality," which importantly is often "concealed," semi-consciously perceived or only dimly recognized. For Bourdieu, this "sense of reality" is integral to social reproduction.

> "That's the experience of the Chicano here, not necessarily being one [American] or the other [Mexican]. You go to Mexico and you're not Mexican…So it's taken a long time for me to understand what that experience was for me, to the point that I knew that education was important and I have always wanted to go to school… But when it came time to get my bachelors [degree], there was a feeling that I was going to lose something. I didn't understand that. A lot of it has to do with my own observing of people and seeing who was where in my world. I felt like if you became an educated person that you would lose who you were, and I didn't want to do that…[It's] having an awareness of how history played on you, how it affected you. You have those senses all your life, but you don't understand them, so it's important for us to talk about them, "my God, now I know" (GK08)
>
> This Director of a community-based organization serving Latino immigrants, noted that at the moment she made her decision about her education, she wasn't fully conscious of what she had observed and internalized. Her decision not to pursue her degree may not have appeared rational to an outsider, and she wouldn't have been able to report or explain it clearly at the time. She had a feeling—a 'sense of reality' or internalized cultural understanding of what education meant in her social context—that constrained her decision-making process.

Individual Behavior in Context

The theoretical approach to social context proposed here takes into account this theoretical understanding of the mutually constitutive relationship of individuals and social structures, the unconscious dispositions of individuals that reflect their social context, and the fluidity of both. For a more concrete understanding of social context, we can consider various interacting realms that all influence the individual and are influenced by the individual. The most immediate includes family interactions, neighborhood, and community relationships and support (e.g. interactions between friends, coworkers, and members of the same community groups, such as church organizations; see also Pasick, Barker, et al., 2009). The contextual realm of institutions or organizations includes the structuring of access and barriers to healthcare and the ability to mobilize resources to get what one needs. It is here that we see the individual institution interfaces, including experiences of welcoming and unwelcoming contexts, and negotiations over services and resources (see also Burke et al. 2009). The political/historical/legal realm includes historical memories (Trouillot 1995), experiences of migration, discrimination, colonization, neocolonization, and decolonization (Strobel 2001), as well as large-scale demographic, politico-economic, cultural and historical factors, laws (e.g. regarding citizenship), regulations, and policies (see also Joseph et al., 2009).

> "….you can access your *loob* [inner self] and you grow to understand its depth and breadth…and how encompassing it is in all aspects of your life. It empowers you and gives you your sense of identity, which is different from your colonial identity…you come home to yourself…you develop [strength]…and get ready to take risks and to act 'cause you have the confidence and sense of power." (KI04)
>
> This Filipino sociologist discussed the impact of the discrimination and "colonial identity" many Filipinos contend with due to the history of relations between the US and the Philippines. This history impedes agency, she argued, and those able to get past this and to access their "inner selves" experience renewed confidence and ability to act. In this way, she shows how colonial identity and historical processes can impact health behavior.

CONCLUSIONS

The need to move behavioral theory beyond the individual level focus to incorporate community, organizational, and systems-level factors – has been noted repeatedly in the field of public health (Emmons, 2000; Frohlich et al., 2001; McKinlay, 1995; Perry et al., 2002; Revenson et al., 2005; Sorensen et al., 2003; Susser & Susser, 1996; Williams, 1995). SCT, through its recognition of the interplay of the individual and her environment and SE models, through the incorporation of multiple levels of influence (interpersonal factors and processes, institutional factors, community factors, and public policy) have made substantial progress in this direction.

The theoretical approach to social context outlined herein differs from both SCT and SE models in several ways. First, rather than describing rather static, fixed levels that are separate from each other and to which different forms of intervention may be directed, social science theory purports that the relationship between the individual and her social context is constantly dynamic, shaped and constituted by social, cultural, economic, political, legal, historical and structural forces. Second, this relationship is multi-directional and co-constitutive. Third, social context encompasses multiple realms including both cultural and social domains of influence, as illustrated in Bourdieu's concept of *habitus* (embodied history, presence of the past). Last, like *habitus,* our concept of social context incorporates elements and processes that are outside conscious awareness. Other articles in this volume, addressing the domains of transculturation, social capital, and relational culture (Joseph et

al.; Burke et al.; and Pasick, Barker et al., respectively) further illustrate our theoretical approach to social context with extensive qualitative data and detailed analytic discussion. These three articles illustrate the patterned yet imperfectly shared realms of social context which arise from individuals and their practices and serve to tie people to their families, communities, organizations, and histories. The influences of these various realms can and should be identified and taken into account in studies of health behavior if the findings of such studies are to contribute to successful public health interventions aimed at changing health behavior.

Implications for Practice

Our purpose was to present a theory-based article to demonstrate the complex nature of health behavior, and the need to attend to the multiple realms of social context at play when women make decisions about their health care. We contend that attention to social context as theorized here illuminates assumptions and limitations of current theories of health behavior and so will enable us to improve theory and, ultimately, to improve health research about, and services for, women. Without an understanding or conceptualization of the context within which women make decisions--including the multiple intersecting realms of context, both conscious and unconscious, which inform those decisions--it is impossible to gauge what these decisions mean to women, and hence to precisely predict the decisions they will make.

Acknowledgments

This work was funded by the National Cancer Institute, grant #RO1CA81816, Pasick, PI. The authors would like to thank the editors and two anonymous reviewers for their comments on earlier versions of this manuscript.

References

Ajzen I. The theory of planned behavior. Organizational behavior and human decision processes. 1991; 50:179–211.

Ajzen, I.; Fishbein, M. Understanding attitudes and predicting social behavior. Englewood Cliffs, N.J: Prentice Hall; 1980.

Bandura, A. Social Foundations of Thought and Action: A Social Cognitive Theory. Englewood, NJ: Prentice Hall; 1986.

Bandura A. Representing personal determinants in causal structures. Psychological Review. 1984; 91:508–511.

Bandura, A. Perceived self-efficacy: Exercise of control through self-belief. In: Dauwalder, JP.; Perrez, M.; Hobi, V., editors. Annual series of European research in behavior therapy. Vol. 2. Amsterdam/Lisse, Netherlands: Swets & Zeitlinger; 1988. p. z27-59.

Bandura A. Social cognitive theory of self-regulation. Organizational Behavior and Human Decision Processes. 1991; 50:248–287.

Bandura, A. A social cognitive approach to the exercise of control over AIDS infection. In: DiClemente, R., editor. Adolescents and AIDS: A generation in jeopardy. Beverly Hills: Sage; 1992. p. 89-116.

Bandura, A. Social Cognitive theory and exercise of control over HIV infection. In: DiClemente, RJ.; Peterson, JL., editors. Preventing Aids: Theories and methods of behavioral interventions. New York: Plenum Press; 1994.

Bandura, A. Self-efficacy: The exercise of control. New York: Freeman; 1997.

Bandura A. Self-efficacy: The foundation of agency. Control of Human Behavior, Mental Processes, and Consciousness. 2000:17–33.

Bandura A. Social cognitive theory in cultural context. Applied Psychology. 2002; 51(2):269–290.

Baranowski, et al. How individuals, environments, and health behavior interact: Social cognitive theory. In: Glanz, K.; Rimer, B.; Lewis, F., editors. Health Behavior and Health Education: Theory, Research, and Practice. San Francisco: Jossey-Bass Publishers; 2002. p. 165-184.

Baumeister RF, Heatherton TF. Self Regulation Failure: An Overview. Psychological Inquiry 1996. 1996; 7(1):1–15.

Becker MH. The health belief model and personal health behavior. Health Educ Monogr. 1974; 2:324–508.

Berkman, LF.; Glass, L. Social integration, social networks, social support, and health. In: Berkman, LF.; Kawachi, I., editors. Social Epidemiology. New York: Oxford University Press; 2000. p. 137-173.

Best A, Stokols D, Green LW, Leischow S, Holmes B, Buchholz K. An integrative framework for community partnering to translate theory into effective health promotion strategy. American Journal of Health Promotion. 2003; 18(2):168–176. [PubMed: 14621414]

Bourdieu, P. The Logic of Practice. Stanford, CA: Stanford University Press; 1990.

Bourdieu, P. Outline of a theory of practice. Cambridge: Cambridge University Press; 1977.

Burke NJ, Bird JA, Clarke M, Rakowski B, Guerra C, Barker JC, Pasick RJ. Social and Cultural Meanings of Self-Efficacy. Hlth Ed & Beh. under review.

Crossley M. Making sense of 'barebacking': Gay men's narratives, unsafe sex and the 'resistance habitus'. British Journal of Social Psychology. 2004; 43:225–244. [PubMed: 15285832]

Dominguez, V. White by definition. Social classification in Creole Louisiana. New Brunswick, NJ: Rutgers University Press; 1986.

Emmons, KM. Health behaviors in a social context. In: Berkman, LF.; Kawachi, I., editors. Social Epidemiology. New York: Oxford University Press; 2000. p. 137-173.

Fang D, Moy E, Colburn L, Hurley J. Racial and ethnic disparities in faculty promotion in academic medicine. JAMA. 2000; 284(9):1085–1092. [PubMed: 10974686]

Frankenberg, R. White women, race matters: The social construction of whiteness. Minneapolis: University of Minnesota Press; 1993.

Frankenberg, R., editor. Displacing whiteness: Essays in social and cultural criticism. London: Duke University Press; 1997.

Frohlich K, Corin E, Potvin L. A theoretical proposal for the relationship between context and disease. Sociology of Health & Illness. 2001; 23(6):776–797.

Geertz; Clifford. The Interpretation of Cultures. New York: Basic Books; 1973.

Giddens, A. The constitution of society. Cambridge: Polity Press; 1984.

Glanz, K.; Lewis, FM.; Rimer, BK. Health behavior and health education: Theory, research and practice. San Francisco: Jossey-Bass; 2002.

Glass T, McAtee MJ. Behavioral science at the crossroads in public health: Extending horizons, envisioning the future. Social Science & Medicine. 2006; 62(7):1650–1671. [PubMed: 16198467]

Hagey R, MacKay RW. Qualitative research to identify racialist discourse: Towards equity in nursing curricula. Int J Nurs Stud. 2000; 37(1):45–56. [PubMed: 10687809]

Hartigan, J. Racial situations: Class predicaments of Whiteness in Detroit. Princeton, NJ: Princeton University Press; 1999.

Jenkins, R. Pierre Bourdieu. Routledge Press; 2002.

Joseph G. Taking race seriously: Whiteness in Argentina's national and transitional imaginary in identities. Global studies in culture and power. 2000; 7(3)

Joseph G, Burke NJ, Tuason N, Pasick RJ. Perceived susceptibility and perceived benefits in the context of transculturation. Health Educ Behav. 2008 Under Review.

Krieger N. Epidemiology and the web of causation: Has anyone seen the spider? Soc Sci Med. 1994; 39:887–903. [PubMed: 7992123]

Krieger N. Theories for social epidemiology in the 21st century: An ecosocial Perspective. Int J Epidemiol. 2001; 30:668–677. [PubMed: 11511581]

Krieger N, Davey Smith G. Bodies count, and body counts: Social epidemiology and embodying inequality. Epidemiol Rev. 2004; 26:92–103. [PubMed: 15234950]

Krieger N, Lowy I, Aronowitz R, Bigby J, Dickersin K, Garner E, Gaudilliere JP, Hinestrosa C, Hubbard R, Johnson PA, Missmer SA, Norsigian J, Pearson C, Rosenberg CE, Rosenberg L, Rosenkrant BG, Seaman B, Sonnenschein C, Soto AM, Thornton J, Weisz G. Hormone replacement therapy, cancer, controversies, and women's health: historical, epidemiological, biological, clinical, and advocacy perspectives. J Epidemiol Community Health. 2005; 59:740–748. [PubMed: 16100311]

Krumeich A, Weijts W, Reddy P, Meijer-Weitz A. The benefits of anthropological approaches for health promotion research and practice. Health Education Research. 2001; 16(2):121–130. [PubMed: 11345657]

Kuhn, T. The structure of Scientific Revolutions. Chicago: University of Chicago Press; 1970.

Latour, B.; Woolgar, S. Laboratory life: The construction of scientific facts. Princeton: Princeton University Press; 1986.

Liu JJ. Gender differences in gastroenterology. Am J Gastroenterol. 2005; 100(2):257–258. [PubMed: 15667478]

McKinlay, JB. The new public health approach to improving physical activity and autonomy in older populations. In: Heikkinen, E.; Kuusinen, J.; Ruoppila, I., editors. Preparation of aging. New York: Plenum Press; 1995. p. 87-103.

Mcleroy K, Bibeau D, Steckler A, Glanz K. An ecological prospective on health promotion programs. Health Education Quarterly. 1988; 15(4):351–377. [PubMed: 3068205]

Pasick RJ, Hiatt RA, Paskett ED. Lessons learned from community-based cancer screening intervention research. Cancer. 2004; 101:1146–1164. [PubMed: 15316912]

Pasick RJ, Burke NJ. *A Critical Review of* Theory in Breast Cancer Screening Promotion Across Cultures. Annual Review of Public Health. 2008; 2008:29.

Pasick RJ, Burke NJ, Bird JA, Barker J, Joseph G, et al. Behavioral Theory in a Diverse Society. Like a Compass on Mars. Health Educ Behav. 2008 Under Review.

Pasick RJ, et al. Intention, Subjective Norms, and Cancer Screening in the Context of Relational Culture. Hlth Ed & Beh. under review.

Perry O, Thompson C, Fowkes G. Cultural Context, Older Age, and Smoking in Scotland. Health Promotion International. 2002; 17(4):309–316. [PubMed: 12406919]

Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: Applications to addictive behaviors. Am Psychologist. 1992; 47(9):1102–1114.

Puzan E. The unbearable whiteness of being (in nursing). Nurs Inq. 2003; 10(3):193–200. [PubMed: 12940974]

Redding C, Rossi J, Rossi SR, Velicer WF, Prochaska JO. Health behaviour models. The International Electronic Journal of Health Education. 2000; 3:180–193.

Revenson TA, Pranikoff JR. A contextual approach to treatment decision making among breast cancer survivors. Health Psychol. 2005; 24(4):93–98.

Roediger, DR. The wages of Whiteness. London: Verson; 1991.

Rosenstock IM. Why people use health services. Milbank Memorial Fund Quarterly. 1966; 44:94–127. [PubMed: 5967464]

Rosenstock IM. The Health Belief Model and Preventive Behaviors. Health Education Monographs. 1974

Sallis, JF.; Owen, N. Ecological Models of Health Behavior. In: Glanz, K.; Rimer, BK.; Lewis, FM., editors. Health Behavior and Health Education. 3. San Francisco, CA: Jossey-Boss; 2008. p. 462-484.

Singer M, Weeks MR. Preventing AIDS in Communities of Color: Anthropology and Social Prevention. Human Org. 1996; 55:488–492.

Smedley, BD.; Syme, SL., editors. Promoting Health: Intervention Strategies from Social and Behavioral Sciences. Washington, DC: National Academy Press; 2000.

Smedley, BD.; Butler, AS.; Bristow, LR., editors. In the nation's compelling interest: Ensuring diversity in the health care workforce. Washington, D.C: The National Academies Press; 2004.

Sorensen G, Emmons K, Hunt MK, Barbeau E, Goldman R, Peterson K, Kuntz K, Stoddard A, Berkman L. Model for incorporating social context in health behaviour interventions: Applications

for cancer prevention for working class, multiethnic populations. Preventive Medicine. 2003; 37:188–197. [PubMed: 12914824]

Susser M, Susser E. Choosing a future for epidemiology: II. From black box to Chinese boxes and eco-epidemiology. Am J Public Health. 1996; 86(5):674–7. [PubMed: 8629718]

Stokols D. Establishing and maintaining healthy environments: Toward a social ecology of health promotion. American Psychologist. 1992; 47(1):6–22. [PubMed: 1539925]

Stockols D. Translating Social Ecological Theory into Guidelines for Health Promotion. American Journal of Health Promotion. 1996; 10:282–298. [PubMed: 10159709]

Strobel, LM. Coming Full Circle: The process of decolonization among post-1965 Filipino Americans. Giraffe Books; 2001.

Terry, DJ.; Hogg, MA. Attitudes, Behavior, and Social Context. New Jersey: Lawrence Erlbaum; 2002.

Triandis H. The self and social behavior in differing cultural contexts. Psychological Review. 1989; 96(3):506–520.

Trouillot, RM. Silencing the past: Power and the production of history. Boston: Beacon Press; 1995.

US Department of Health and Human Services. Healthy People 2010 Conference edition in two volumes. Washington, DC: Department of Health and Human Services;

Weinstein ND. Testing four competing theories of health-protective behavior. Health Psychology. 1993; 12(4):324–333. [PubMed: 8404807]

Williams S. Theorising class, health and lifestyles: Can Bourdieu help us? Sociology of Health & Illness. 1995; 17(5):577–604.

Yancey A, Kagawa-Singer M, Ratliff P, Valdez A, Jimenez L, Banks P, Stewart S, Pasick RJ. Progress in the Pipeline: Replication of the Minority Training Program in Cancer Control Research. Journal of Cancer Education. Winter;2006 21(4):230–6. [PubMed: 17542715]

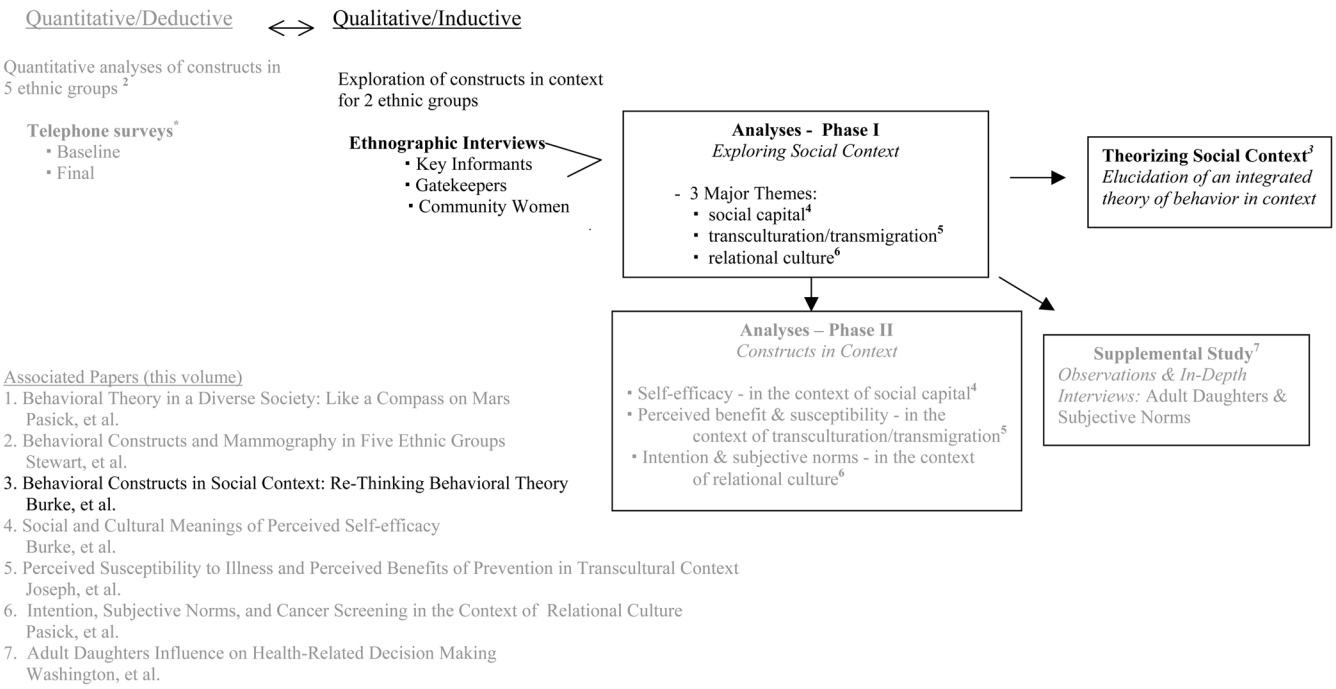

Figure 1. Behavioral Constructs & Culture in Cancer Screening (3Cs) Study Design & Associated Reports[1]

*Access & Early Detection for the Underserved- *Pathfinders* 1998–2003

A mammography & Pap screening intervention trial underway when 3Cs began