Message Framing and Defensive Processing: A Cultural Examination

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Past research has shown that health messages on safer sexual practices that focus on relational consequences are more persuasive than messages that focus on personal consequences. However, we theorize that it is defensiveness against personal risk framing that threatens the self among people from more individualistic cultures. Two studies tested this idea. Study 1 showed that European Americans were less persuaded by personal framing than by relational framing but that this pattern was not found for Asian Americans, who are more collectivistic. Study 2 showed that these defensive patterns were eliminated among European American participants when a person’s self-image was affirmed. These results suggest defensive processes as the mechanism behind the differences in message framing effectiveness and motivate a closer look at cultural patterns.

Rigorous campaigns to educate individuals to engage in more healthy behaviors, such as not smoking, healthier dieting, or safer sex, have encouraged much research on how to effectively construct impactful messages. Health messages are designed to not only inform the reader, but also to grasp a reader’s attention and persuade the reader to change behaviors or beliefs in light of the new information. One factor that has been shown to impact the effectiveness of health messages is their framing. Previous research (e.g., Rothman & Salovey, 1997) has found that the specific framing of health messages can increase the effectiveness of these messages. In addition, framing messages to match the nature of the issue at hand and to the dispositional tendencies of the target audience can lead people to accept the information, recognize its self-relevance, and encourage behavioral changes.

One example is the use of personal or relational framing of a health message. Previous research shows that relational framing of HIV/AIDS information in general is more persuasive than personal framing, even with the same content of the message. However, the mechanism that underlies the effect is unclear. Some researchers (Kellar-Guenther, 1999; Kiene, Barta, Zelenski, & Cothran, 2005) have proposed that relational framing is more effective because it focuses on the domain that matters more to people (i.e., close relationships) than personal framing. However, another possibility that we propose is that personal framing is more threatening than relational framing and thus activates defensive processes that lead to the rejection of the message (cf. Liberman & Chaiken, 1992). The present research aims to test these potential mechanisms, in two studies: one that compares the effectiveness of these frames among two cultural groups that differ in their emphasis of the personal or relational aspects of the self and one that utilizes self-affirmation to buffer against the threat of health messages. In so doing, we aim (a) to examine whether there is a cultural difference in the effectiveness of a particular message framing, and (b) to test a psychological mechanism underlying the differential effectiveness of specific framings.

FRAMING OF HEALTH MESSAGES

Much research has been dedicated to the effectiveness of different framing of health messages and the understanding of underlying mechanisms (e.g., Mann, Sherman, & Updegraff, 2004; Rothman & Salovey, 1997). One specific case is the relational versus personal framing of health messages. Kiene and colleagues (2005) primed participants with either personal risk (e.g., carrying condoms to protect oneself) or relational risk messages (e.g., discussing condoms with a partner). They found that gain-frames were more effective with personal risk framing and loss-frames were more
effective with relational risk framing. The authors inferred from these results that participants saw relational concerns as more risky than personal health concerns when they were considering information on sexually transmitted infections (STIs)/HIV.

Other researchers have also suggested that individuals may find personal health concerns to be less risky than relational concerns. Sexually active individuals are often knowledgeable about how HIV is contracted, as well as the preventative steps they may take to protect themselves, such as using condoms and talking to their partners (DiClemente, Forrest, & Mickler, 1990). However, this information does not seem to deter individuals from engaging in unsafe sexual behaviors. Kellar-Guenther (1999) argued that the drive to maintain a solid romantic relationship may be more important than personal health, and suggested focusing on the motivation to protect partners and relationships from such consequences. Consistent with Kellar-Guenther’s prediction, Reel and Thompson (1994) found that “other-oriented” strategies such as using “we” statements were considered more effective in leading participants to report intentions to use condoms.

In sum, the growing literature acknowledges the importance of relational concerns in understanding safer sex practices. Much of this research assumes that relationships are more important than personal health concerns and the potential of troubling those relationships is riskier than potential personal consequences. The assumptions of this research have suggested that relationally framed messages are more effective than personally framed messages.

**EGO DEFENSE AND THREATS TO SELF**

Research on motivational processing of threat, however, presents an alternative account for the difference in effectiveness of personal and relational framing. This line of research has shown that when information on health risks threatens the self, individuals are motivated to defend themselves against these threats (Kunda, 1990). Individuals often reject, ignore, or downplay the seriousness of issues that are relevant to them because it is too threatening (Jemmott, Ditto, & Croyle, 1986). Morris and Swann (1996) found that sexually active participants who saw potentially threatening AIDS/HIV informational videos lowered their ratings of perceived risk.

Ironically, messages that are highly threatening, such as messages relevant to the central aspects of the self, lead to activation of self-defensive processes. Consequently, this leads to rejection of the messages. Liberman and Chaiken (1992) suggest that individuals adhere to information when it is self-relevant and mildly threatening, but activate biased systematic processes in defense toward highly threatening messages. According to this view, it may be the case that health messages that are centered on personal risks have been less persuasive than messages on relational risks, not because relationships are more important to these individuals, but because the former is too threatening.

One way to test the validity of these two competing explanations is by looking at the reactions to these messages among people from different cultures with a relatively different emphasis on the individual versus relationship. Thus, in Study 1, we compared people from a more individualistic culture (i.e., European Americans) and people from a more collectivistic culture (i.e., Asian Americans) in how they respond to different framings of a health message. Another way to test these competing explanations is by providing participants with a means to reduce psychological defensiveness and examining how such a manipulation affects the way in which people respond to different framings of a health message. Thus, in Study 2, we tested the role of defensiveness by utilizing the self-affirmation method as a means to reduce defensiveness.

**STUDY 1**

In most studies on health message framing, participants are primarily sampled from individualistic cultures such as in Western Europe or North America. Cultural psychology research has shown that cultures differ in the relative importance placed on individuals and on relationships. This presents an opportunity to test the relational hypothesis proposed by Kellar-Guenthar (1999). Markus and Kitayama (1991) posit that the independent self-construal, encouraged in individualistic cultures such as in North America, sees the self as bounded and separated from close others. Those with independent self-construals may be more defensive toward threats to the independent self such as personal health risks. In contrast, the interdependent self-construal (Markus & Kitayama, 1991), encouraged most distinctly in collectivistic cultures such as in Asia, sees the self as intertwined and connected with close others. Those with interdependent self-construals may be more defensive toward threats to the interdependent self, such as relational risks. These views of the self may impact priorities and health behaviors.

Previous research shows that Asians and Asian Americans prioritize group or relational goals over personal goals more than European Americans do, in order to maintain harmony and stability in their relationships with others (Kim, Sherman, Ko & Taylor, 2006). This emphasis placed on relational interdependence in Asian cultures is also supported by studies looking at maintenance of relational harmony between group members in cooperative activities (Yuki, Maddux, Brewer, & Takemura, 2005).

Consequently, these self-construals and cultural values affect health-related behaviors in communication, as Asian Americans have been shown to disclose less and seek out health services less than European Americans (Matsuoka, Breaux, & Ryunjin, 1997) in order to save family face and
diminish collective shame (Ting-Toomey, 2005). Yoshioka and Schustack (2001) have shown that Asian American men diagnosed with HIV were reluctant to disclose their health status because of concerns of appearing demanding or obliging of family help and instrumental support.

These cultural differences may influence not only what people do, but also how they process health messages. Analyses on individualism and collectivism support the importance of framing on an individual level. Dutta-Bergman (2003) showed that those who scored higher on individualism would be more persuaded by messages that focused on functional appeals that dealt with maintenance of one’s health. Likewise, those who scored lower on individualism would be more persuaded by messages that focused on social appeals that dealt with maintenance of one’s group affiliations (Dutta-Bergman, 2003). It is important to note that these framing studies use messages that are gain-framed, not loss-framed, which may elicit defensive processes. However they lend support to the idea that culture influences what information one attends to and finds personally relevant. Thus, a comparison between these two different cultural views provides an opportunity to test which of the two different explanations underlie the effectiveness of relational framing found in previous research (i.e., of protecting relationships vs. of defensiveness) primarily using European American samples. For people from cultures that place less importance on the individual self and thus who may not be as motivated to defend the individual self, will the relational framing persuade them more or less than the personal framing?

The present research focused on whether or not there were cultural differences in reactions to personal and relational message framing. If the explanation offered by Kellar-Guenther’s (1999) and Kiene and colleagues (2005) is valid, there should be increases in effectiveness of relational framing among Asian Americans since preference for relationally framed messages is a product of the higher priority placed upon relationships over personal concerns. However, as we hypothesize that this greater effectiveness of relational framing is due to defensiveness against personal framing, we predicted that European Americans should be persuaded by the relational risk-framed message more than by the personal risk-framed message because it will be less threatening to the individual self. In contrast, Asian Americans should not be as persuaded by relationally framed messages any more than by personal risk framed messages. If anything, they may be less persuaded by relational risk-framed messages than by personal health-risk-framed messages because of their stronger focus on groups and relationships.

Method

Participants

One hundred and twenty-five undergraduates at the University of California, Santa Barbara, participated for either credit or payment. They were preselected on the basis of ethnicity (61 European Americans and 64 Asian Americans, 32 males, 93 females). This was a 2 (culture: Asian American vs. European American) by 2 (frame: personal vs. relational) factorial design.

Materials

Brochures. Two brochures, identical in design, were created to highlight the devastating psychological and physical consequences of failing to use condoms while engaging in sexual behavior as well as to provide statistics and information on STIs and HIV/AIDS. However, the two brochures differed in how they were framed. The personal-risk-framed brochure illustrated the consequences to the individual person (i.e., “I felt ashamed and sad,” “I think about the added stress on my life”), and the relational-risk-framed brochure illustrated the identical consequences in relation to close others (i.e., “My parents felt ashamed and sad,” “I think about the added stress on my life partner”). The personal-risk-framed brochure was titled “Our Health, Our Lives” and the relational-risk-framed brochure was titled “Our Health, Our Loved Ones.”

Questionnaires. As dependent measures, two questionnaires were created to assess reactions to the brochure as well as beliefs about health. The first questionnaire contained questions related to the reactions to the brochure (e.g., “How relevant did you feel the information in the brochure was?”) and future behavioral health intentions (e.g., “In the future, how likely is it that you will use condoms during intercourse?”). The second questionnaire was comprised of items measuring beliefs about health including self-efficacy (e.g., “How much control do you have in using condoms during sex?”). Participants rated each statement in terms of how much they followed the behavior or agreed with the statement on 9-point Likert-type scales anchored at 1 (not at all) and 9 (very much).

Procedures

Participants were told that this study was looking at the effectiveness of new health brochures promoting condom usage. They were then randomly assigned to one of the two conditions and given either the personal or relational risk framed brochure. Participants were instructed to read and evaluate the health brochure by responding to the items on the questionnaires. After participants filled out the questionnaires, they were thanked for their participation and debriefed.

Results

A series of 2 (Asian American vs. European American) by 2 (personal frame vs. relational frame) analysis of covariance (ANCOVAs) was performed with the total number of sex partners, recent degree of sexual activity, and the past STI
diagnosis as covariates. These variables were covaried out because these variables could affect how much risk participants perceived beyond the information of the brochure message.

**Effectiveness of the brochure.** Participants responded to three questions addressing brochure reception (“How effective did you feel the brochure was?” “How relevant is this information to you?” and “How interested are you in learning more information about topics covered in the brochure?”). These questions were combined to form a composite variable of brochure persuasion because they matched different components of persuasion: relevance, interest, and perceived effectiveness. Therefore, although a reliability analysis yielded only a moderate alpha level (α = .58), they were combined for theoretical reasons. A 2 by 2 ANCOVA showed no main effects of ethnicity, F(1, 112) = .003, p = .96, or framing, F(1, 112) = .003, p = .96. There was a predicted significant two-way interaction, F(1, 112) = 3.97, p = .05 (see Figure 1).

A pairwise comparison showed that although European Americans evaluated the relational-risk-framed brochure more favorably (M = 6.00, SD = 1.28) than the personal-risk-framed brochure (M = 5.62, SD = 1.21), this difference was not statistically significant, p = .15. Asian Americans did not significantly differ either, although, unlike European Americans, they evaluated the relational-risk-framed brochure (M = 5.46, SD = 1.71) less favorably than the personal-risk-framed brochure (M = 5.90, SD = 1.72), p = .16. As with the future condom usage, the data show that European Americans are more affected by the relational-risk-framed messages compared with Asian Americans.

**Self-efficacy.** Participants responded to a composite question on control. Five statements assessing control were used: “It is easy to use condoms during sex,” “My sexuality is something I am responsible for,” “I feel like my physical health is something that I myself am in charge of,” “My health is something that I alone am responsible for,” and “The status of my health is determined largely by what I do (and don’t do).” The internal consistency for this composite variable of control was acceptable (α = .71). A 2 by 2 ANCOVA revealed that there were no significant main effects of ethnicity, F(1, 109) = .55, p = .46, or of framing, F(1, 109) = .96, p = .33. There was a significant predicted interaction, F(1, 109) = 5.19, p = .03. A pairwise comparison revealed that European Americans reported less control with the personal-risk-framed brochure (M = 7.86, SD = .92) than with the relational-risk-framed brochure (M = 8.31, SD = .70), p = .03. Asian Americans did not differ in their reported control with the personal-risk-framed brochure (M = 8.23, SD = .74) and with the relational-risk-framed brochure (M = 8.05, SD = .98), p = .33.

**Behavioral intention.** This measure consisted of two items on future intentions to get tested for STIs and future intentions to use condoms during sex (r = .35, p < .001). A 2 (culture: Asian American vs. European American) by 2 (frame: personal vs. relational) ANCOVA was performed on future intentions to use condoms during sex. There were no significant main effects of ethnicity, F(1, 112 ) = .04, p = .84, or framing F(1, 112) = .34, p = .56. There was a significant two-way interaction, F(1, 112) = 9.83, p = .002. Pairwise comparisons revealed that European Americans reported less intention to use condoms in the future from the personal-risk-framed brochure (M = 6.79, SD = 2.12) than from the relational-risk-framed brochure (M = 7.87, SD = 1.25), p = .01. Asian Americans did not differ in their reported intention to use condoms in the future in terms of whether they received the relational-risk-framed brochure (M = 6.51, SD = 2.59) or the personal-risk-framed brochure (M = 7.41, SD = 1.54), p = .06.

**Discussion**

In Study 1, cultural comparisons provided evidence for the self-defensiveness hypothesis. European Americans from a more individualistic culture were more persuaded by the relationally framed message than by the personally framed message and Asian Americans from a more collectivistic culture did not show the same tendency. European Americans were somewhat more likely to find the health issue relevant, felt more in control over using condoms, and were more likely to report higher future intentions to use condoms when reading the relational-risk-framed message than when reading the personal health-risk-framed message. In contrast, Asian Americans were not more persuaded by relational framing than by personal framing of the message.

Thus, Study 1 provides initial evidence that there are cultural differences in the effectiveness of personal and relational framings of messages. This pattern of results is consistent with the explanation that defensiveness to a self-threat underlies the greater effectiveness of relational framing among European Americans. Building on these findings, in Study 2 we sought to provide further evidence that the present pattern is affected by defensiveness to threat.
STUDY 2

The Study 2 hypotheses and design were informed by self-affirmation theory. Self-affirmation theory (Steele, 1988) states that because of people’s desire for competence and self-worth in a constellation of domains, threats to any one of these self-relevant domains can elicit a defensive response. However, affirming other important unrelated domains of the self may diminish the threat. Thus reducing threat through self-affirmation makes the self more resilient to criticism and more receptive to threatening information. We chose this paradigm because it is very difficult to directly measure defensiveness because asking participants directly whether they are defensive may be threatening and they may be unaware of the causes for their own actions. Most literature on defensiveness and threat thus relies on indirect ways such as self-affirmation in order to examine whether or not a given psychological response is motivated by defensiveness (e.g., see Sherman & Cohen, 2006 for a comprehensive review). Evidence supporting self-affirmation shows that it is linked to reducing bias and approaching opposing messages more dispassionately and open-mindedly (Correll, Spencer, & Zanna, 2004). A study conducted by Sherman, Nelson, and Steele (2000) showed that self-affirmation could decrease defensiveness when watching a video about HIV/AIDS. They found that the self-affirmed participants perceived more risk, purchased more condoms, and took more informational brochures than the non-affirmed participants.

In this study, we aimed to examine the effect of self-affirmation among European Americans, the group that was differentially affected by the framing of the health message. If the results with European Americans that we obtained in Study 1 are due to defensiveness, implementing self-affirmation should reduce this bias. Thus, we hypothesized that in the control condition, the results would replicate the findings from Study 1. However, when self-affirmed, we predicted that European American participants should be equally persuaded by personal and relational risk framings. In addition, we also aimed to measure the effect of experimental manipulation on the actual behavior of participants.

Method

Participants. Eighty-six European American undergraduates (22 men and 64 women) from the University of California, Santa Barbara, participated in this study, compensated by course credit in an Introductory Psychology course or $10. This was a 2 (affirmation: affirmed vs. control) by 2 (frame: personal vs. relational) factorial design. In this study, we included only European American participants because Asian Americans in Study 1 did not differ in their preference for either framing.

Materials. The two brochures, personal-risk-framed and relational-risk-framed, as well as the questionnaires were the same stimuli used in Study 1. The questionnaires contained measures of persuasiveness of the brochures, perceived risk, and future behavioral intention.

Procedure. We used a success feedback manipulation as the domain of academic success as a way to affirm participants’ self-image. In the affirmation condition, they were given a 10-item easy version of the Remote Associations Task (as used in Dunning, Leuenberger & Sherman, 1995) to complete within 5 min. Once they had completed the task, they were told that their score was in the top 10%. They were then told to read and evaluate a brochure on HIV transmission and rates of contraction as in Study 1. At the end of the questionnaire, the experimenter entered the room and asked the participant to complete a final summary and demographic questionnaire. In the control condition, they were not given the Remote Association Task and simply completed the brochure evaluation task as in Study 1. At the end of the session, participants were told that the research was funded by the University Health Services (UHS), and thus the university was providing free pamphlets on sexual health, safer sex, and STI/HIV/AIDS information if participants were interested in acquiring more information. Furthermore, they were told that the UHS was providing condoms to participants for a purchase price of 10 cents. We provided a change box for students if they did not have exact change to purchase condoms. It was stressed that the purchase of condoms was based on the honor system and that they had no obligation to take any items if they did not want to. The experimenter asked the participants if they had any questions and closed the door in order to insure privacy. After, participants were debriefed and thanked.

Results

Analyses focused on the extent to which participants were persuaded by the brochure, perceived risk of contracting HIV, and future intentions to be tested for STIs. A series of 2 (affirmed vs. control) by 2 (personal frame vs. relational frame) ANCOVAs was performed with total partners, sex, and relational-risk-framed, as well as the questionnaires on the composite variable used in Study 1 with one additional question (“It is important to be informed about safer sex”) (α = .63). On this dependent variable, the ANCOVA showed no main effects of frame, F(1, 79) = 2.20, p = .14, or affirmation, F(1, 79) = 1.01, p = .31. However, there was a predicted significant frame by affirmation interaction, F(1, 79) = 4.34, p = .04. Planned pairwise comparisons revealed that participants in the control condition were more persuaded by the relationally framed brochure (M = 6.63, SD = 1.13) than by the personally framed brochure (M = 5.68, SD = 1.06), p = .03. In contrast, supporting our hypothesis,

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the affirmation manipulation eliminated the bias and showed that participants in the affirmed condition were equally persuaded by both frames ($M = 5.97$, $SD = 1.28$ for the relational framing and $M = 6.06$, $SD = 1.30$ for the personal framing), $p = .62$ (see Figure 2).

**Perceived personal risk for HIV.** After reading the brochure, participants were asked how at risk they felt that they are in contracting HIV and also how at risk they felt that their peers (i.e., average UCSB students) are in contracting HIV, and these two items formed a composite measure of the perceived risk ($r = .29$, $p = .007$). An ANCOVA revealed no main effects of frame, $F(1, 79) = .31$, $p = .86$, and no main effect of affirmation, $F(1, 79) = 2.63$, $p = .11$. However, there was a predicted significant frame by affirmation interaction, $F(1, 79) = 9.52$, $p = .003$. Planned pairwise comparisons revealed that participants in the control condition felt more at risk with the relationally framed brochure ($M = 5.07$, $SD = 1.52$) than with the personally framed brochure ($M = 3.94$, $SD = 1.20$), $p = .04$. In contrast, supporting our hypothesis, the affirmation manipulation in fact reversed the bias and showed that participants in the affirmed condition felt more at risk with the personal frame ($M = 4.44$, $SD = 1.47$) than with the relational framing ($M = 3.64$, $SD = 1.54$ for the personal framing), $p = .22$.

**Future intention and behavior.** After reading the brochure, participants also indicated their future behavioral intention of being tested for STI and HIV. This measure was combined with the measure of how many STI information brochures participants took at the end of the study to yield a composite measure of behavioral intention ($r = .22$, $p = .04$). An ANCOVA revealed no main effects of frame, $F(1, 79) = .26$, $p = .61$, and no main effect of affirmation, $F(1, 79) = 1.64$, $p = .20$. However, there was a predicted significant frame by affirmation interaction, $F(1, 79) = 4.01$, $p = .05$. Planned pairwise comparisons revealed that participants in the control condition showed a nonsignificant trend of greater behavioral intention to find out more about STI and HIV after reading the relationally framed brochure ($M = 4.04$, $SD = 1.15$) than the personally framed brochure ($M = 3.17$, $SD = 1.68$), $p = .11$. The affirmation manipulation reversed the trend, although nonsignificantly. In this condition, participants showed the trend of greater behavioral intention to find out more about STI and HIV after reading the relationally framed brochure ($M = 3.25$, $SD = 1.53$) than the personally framed brochure ($M = 3.61$, $SD = 1.44$), $p = .23$.

**Discussion**

Study 2 provides further support for our hypothesis that greater effectiveness of the relational risk framed message found among European Americans in previous research is indeed a consequence of defensiveness against a threatening personal risk framed message. The control condition of this study replicated the results of European American participants from Study 1. They were less persuaded by the brochure, perceived less risk to HIV, and showed somewhat less behavioral evidence for the motivation to learn more about HIV after reading the personal-risk-framed message as opposed to the relational-risk-framed message. More importantly, when participants were buffered by a self-affirming event, the personally framed message became equally or even more effective than the relationally framed message for these three variables.

**GENERAL DISCUSSION**

**Summary**

These studies support our hypothesis that greater effectiveness of relationally framed messages previously found (Kiene et al., 2005) is due to a defensive reaction toward threatening personally framed messages. Moreover, these studies show that this seemingly superior effectiveness of relational framing is culturally specific. In Study 1, we hypothesized that European Americans would be more defensive toward personally framed messages because they threatened the individual self. However, Asian Americans from cultures with less emphasis on the individual self should not show this effect. Indeed, Study 1 confirmed that this effect occurred for European Americans but not for Asian Americans. Moreover, Study 2 provided further evidence to support our claim that the reaction seen in European Americans was due to defensiveness by using a threat-buffering paradigm: self-affirmation. If individuals were defensively reacting to the threatening message, then self-affirmation would have an effect. In line with our predictions, self-affirmation did diminish the defensive reaction to personally framed messages for European Americans and led them to accept the message more readily.
Limitations and Future Research

We should acknowledge some limitations to our studies. Our Asian American sample was primarily United States-born participants whose first language was English. Future testing of these effects in Asia or with a primarily first-generation sample may yield stronger effects, such as significant preference for personal-risk-framed messages over relational-risk-framed messages, because adherence to the interdependent self-construal may be stronger for this population than for Asian Americans in our sample.

This study only looks at the future behavioral intentions of participants and their behaviors immediately following the manipulation, but the long-term behavioral effects of these brochures have not been assessed. Possible future studies may look at long-term behavioral changes after reading different brochures over a period of time to assess the relationship between intent and action. In addition, future studies may also look at impacts of relational and personal framed messages in domains that are inherently more personal (e.g., flossing, sunscreen) to lend further support to our defensive processing hypothesis.

Implications for Health Education

The present findings have implications for how health messages, especially highly threatening topics such as HIV, should be approached. Our findings emphasize the importance of acknowledging self-relevant threats associated with HIV information that may prevent individuals from fully processing and accepting health messages. It also provides a possible underlying reason for why shifting messages from personal risk to relational risk is so effective. Further work on finding messages that create fear but not defensiveness or work on using defensive buffers such as self-affirmation is needed.

In addition, persuasion strategies used in health messaging, such as framing the nature of the problem (e.g., relationships and condoms; Kiene et al., 2005) or framing in terms of priorities (e.g., relationships; Kellar-Guenther, 1999), have looked at mainly European American samples. The present research suggests that the effectiveness of framing may differ depending on the culture. Our findings urge a deeper look at the role of culture in message processing and threat defenses, as HIV is not just a European American epidemic. African Americans and Hispanics account for 58% of all HIV cases since 1981 (CDC, 2005). Moreover, HIV is considered a growing epidemic in Asian countries, with an increase of 1 million contracting the virus in 2003 (UNAIDS/WHO, 2003). In order to create effective and persuasive strategies to inform and influence the public, further research on types of threats that are culturally specific may help create more successful and relevant messages. Finding a balance that cautions individuals about the true dangers of HIV and risky sexual behavior but at the same time focuses away from the self may be difficult, but may be the way to truly impact communities.

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