Volume 6 Issue 2 - May 2012

CONTENTS

EDITORIAL
Welcome To MSo Volume 6 Issue 2 .................... 2
Jacqueline Watts

PEER REVIEWED ARTICLES
Health Disparities in Colorectal Cancer Screening in the United States: An Application of the Social Ecological Model .......... 3
Dana M. Greene
Negative Social Exchanges, Acculturation-Related Factors, and Mental Health among Asian Americans ................................................................. 12
Wei Zhang

COMMENTARIES
Raising the profile of 'Elder Abuse' as sociologists: a call from Richenda Power (18/6/2013: Article removed pending receipt of Legal advice) ........ 30
Richenda Power
Does Therapeutic Massage Support Mental Well-Being? ................................................................. 43
Joyce Cavaye

BOOK REVIEWS
Alexander Edmonds: Pretty Modern: Beauty, Sex, and Plastic Surgery in Brazil ................................. 51
Reviewer: Aoife McKenna
Richard J. McNally: What is Mental Illness? ...... 54
Reviewers: Caitlin Rivers and Justin Snyder
A Readers Digest .................................................. 57
Jacqueline Watts
Editorial

Jacqueline Watts
Editor-in-Chief

Welcome to this, the second issue of MSo edited by the team from The Open University. It includes a wide variety of content to engage readers including peer-reviewed articles, commentaries and book reviews.

In the first article, Dana Greene’s discussion of colorectal cancer, draws on a social ecological model to identify possible interventions against unhealthy behaviours associated with screening for this condition. The second article, by Wei Zhang, explores the impact of social exchanges (positive and negative) on psychological distress amongst Asian Americans. Both these pieces provide interesting perspectives on very different but serious health issues that impact significantly on society.

The two commentaries in this issue bring to our attention different and important areas within medical sociology. Richenda Power’s case study of elder abuse raises a number of practical and ethical dilemmas for health and social care professionals as well as for the justice system. Joyce Cavaye’s commentary considers the effectiveness of therapeutic massage in supporting mental well-being. This therapy, along with the whole field of complimentary and alternative medicine, continues to be contested and we would welcome other perspectives on this topic to extend the debate.

We round off this issue with a trio of book reviews covering mental illness, cosmetic surgery and death & dying.

As we approach the end of our first year of editing MSo, I think it is a good time to remind readers that MSo offers a platform, not just for peer-reviewed articles, but also for commentaries, debates, controversies, book reviews and news items. We look forward to your contributions!
Health Disparities in Colorectal Cancer Screening in the United States: An Application of the Social Ecological Model

Dana M. Greene, Ph.D., M.A

Institute for the Environment
University of North Carolina, USA

greenedm@email.unc.edu

ABSTRACT

Colorectal cancer (CRC) is the third most common cancer in the United States, yet the screening rate remains extremely low among certain populations, thereby making colorectal cancer screening an important and urgent public health issue. While it is well known among medical practitioners that CRC is almost 100% preventable if screened for and caught early, there exist significant racial, ethnic, socioeconomic, educational, and regional disparities with regard to those populations who are screened for CRC early and often, and those for whom are not. This paper draws upon the social ecological perspective to evaluate these social inequities in the US healthcare system and focuses primarily on the intersection between individual and ecological factors in the screening factors to identify possible interventions against unhealthy behaviours associated with CRC (i.e., neglecting to be screened).

INTRODUCTION

Colorectal cancer (CRC) is the third most common cancer in the United States, yet the screening rate for this disease remains extremely low, most notably among African Americans, thereby making colorectal cancer screening an important and urgent public health issue (Ananthakrishnan et al, 2007). While CRC is almost 100% preventable if screened for and caught early, there exist significant racial, ethnic, socioeconomic, educational, and regional disparities with regard to those populations who are screened for CRC early and often, and those for whom are not (James, et al, 2006). Current CRC screening guidelines are published by the US Preventative Services Task Force for all people of average risk, and are straightforward and simple: all people over the age of 50 should have at least one, if not more of the following tests on a regular basis: a fecal occult blood test (FOBT) annually, a flexible sigmoidoscopy examination (FSIG) every five (5) years, a double-contrast barium enema (DCBE) every five (5) years, a FOBT and a FSIG every five (5) years, and a screening colonoscopy every ten (10) years (Ananthakrishnan et al, 2007). Given that CRC is 100% preventable, it is imperative that those specializing in public health practices take a strong look at the real and perceived barriers to CRC screening, and posit necessary interventions so that the CRC-related death rate will begin to drop. Per the American Cancer Society, during 2010, there were “102,900 new cases of colon cancer diagnosed (49,470 in men and 53,430 in women, and 39,670 new cases of rectal cancer diagnosed (22,630 in men and 17,050 in women)” (http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics). These numbers, while alarmingly high, do not break down the incidence of CRC among racial and ethnic minorities, the under or uneducated, those living at or below the poverty line (low SES ≤ $10,289) (http://www.irp.wisc.edu/faqs/faq1.htm), and those for whom access to a testing centre is limited or non-existent. As such, the associated death
rate, however, for African Americans is double that of the white population (O’Malley et al, 2005).

This paper takes a social ecological approach to CRC by focusing primarily on the intersection between individual and ecological factors in the screening process to identify possible interventions against unhealthy behaviours (i.e., neglecting to be screened) with the hope of creating a social environment that consists of more health conscious citizens (i.e., more people are screened and the significant health concerns relating to CRC become a thing of the past) (McLeroy et al, 1998).

COLORECTAL CANCER SCREENING AS A PUBLIC HEALTH PROBLEM AND ISSUE

In his seminal book entitled The Sociological Imagination, sociologist C. Wright Mills notes that issues in society may be viewed as both trouble and issues. His framework may be extended to the social ecological framework in such a way that a diagnosis with CRC may be termed a personal trouble if the diagnosis impacts only one person, but when there are competing events that influence barriers or gateways (including issues of social capital) to CRC screening, such becomes a social issue (in “The Sociological Imagination,” 1954). As such, and as will be demonstrated, racial/ethnic and socio-economic (SES) disparities in CRC screening represent a notable social and public health issue.

In 1998, the Centers for Medicare (insurance available to those 65 and older) and Medicaid (insurance available to those with a demonstrated financial need) began reimbursing the costs of “commonly used CRC [screening] tests, covering 100% of charges for FSIG and colonoscopy for high-risk individuals. Coverage was extended to include colonoscopy [screening] for average risk individuals in July, 2001” (Ko et al, 2005, p. 1-2). Whether a patient has health insurance (either private insurance or Medicare/ Medicaid, but there is nothing that guarantees that a patient will have any type of insurance, as is the case in European nations) represents an interesting variable in determining whether that patient will undergo the recommended CRC screening, as data indicates that despite guidelines indicating who should be screened and at which intervals, patient follow-through with recommended CRC testing remains low – especially for racial and ethnic minorities and those in lower socioeconomic brackets. This trend perpetuates within these populations despite assurances of full and complete Medicare or Medicaid reimbursement for the tests, yet analyses have shown that having insurance coverage for screening tests does not eliminate the disparities in CRC screening utilization. Instead, trends indicate that other mitigating factors may exist that prevent poor racial and ethnic minorities from undergoing CRC screening. Among these factors are the embarrassing nature of the tests, general awkwardness of collecting and storing stool samples at home, or even discussing bowel-related issues with doctors. As such, patients tend to shy away from medical tests involving the collection of stool, because “people find them stigmatizing and embarrassing” (http://coloncancer.about.com/b/2011/12/08/stool-testing-what-it-says-about-your-colon.htm). It is clear therefore, that embarrassment at obtaining stool samples presents a mitigating factor against regular CRC screening – especially among racial and ethnic minorities and members of the lower and working class (Robb et al, 2008). Consequently, having medical insurance coverage for CRC screening, while confounded by race/ethnicity and SES, present interesting data on the prevalence (or lack thereof) of consistent CRC screening among vulnerable populations. To further demonstrate this point, and owing to this already alarming trend, Cynthia W. Ko, et al studied demographic differences in CRC screening, and noted that 9.2% of the beneficiaries were likely to consent to a FOBT, but fewer people (7.2%) followed through with a recommended colonoscopy, FSIG, or DCBE (Ko et al, 2005).
This trend is not unique to Ko et al’s study, however. Further research has indicated that African Americans are less likely to report having had a screening colonoscopy within the last ten years citing lack of insurance as a rationale for not getting the test. This finding is furthered by the points offered by McAlearney, et al that low income (<$15,000) African American women have exceptionally low rates of CRC screening, despite the guidelines, and these findings are further impacted by significant social contributors to lower SES, including lower levels of education, awareness of CRC screening protocols, and perceptions that health insurance will not cover bills and lower age (McAlearney et al, 2007). The variable “awareness of CRC screening protocols” represents a significant factor in future public health interventions (to be discussed later), as whites are more likely than Blacks to know about the tests that screen for CRC, that, in turn, influences compliance with medical protocols (ibid). Even when patients are educated about CRC screening protocols, data indicate that there still exist racial disparities in CRC screening follow-through, with patients noting specific barriers to testing, including fear of screening results, embarrassment of specimen collection, not knowing where to get a FSIG, lack of time, and high cost. Among African Americans, specifically, rates of CRC screening compliance are particularly low, while whites are more likely than other racial group to receive any kind of CRC screening test. Further, while rural residents are more likely to have a FOBT done, they are also less likely to receive invasive (FSIG or colonoscopy) screening tests (Ko et al, 2005). Moreover, it has become clear in the literature that while whites receive CRC screening tests earlier and more often, racial and ethnic minorities are more likely to go to the doctor and undergo CRC screening tests if health problems are already being experienced. This, in turn, relates to the higher rates of CRC diagnoses as well as with the associated increased morbidity and mortality rates among racial and ethnic minorities in the United States (James et al, 2006).

Significant racial, ethnic, and SES disparities in CRC testing have resulted in documented differences in CRC outcomes, with higher morbidity (being diagnosed in the later stages of the disease instead of receiving regular colonoscopy or FSIG screening tests that could detect precancerous adenomatous polyps and during which a polypectomy may be performed that would potentially eliminate the possibility that CRC will develop in these individuals) and accompanying higher mortality rates among African Americans and Hispanics (Cooper et al, 2006). The question remains whether the information glitch exists on the part of the patients or on the part of the healthcare delivery system. Regardless, racial disparities exist not only in the implementation of CRC screening procedures, but also in the indications for such testing. Significantly, African Americans are diagnosed more frequently with CRC at later stages of the disease, suggesting that there may be parity in how health care providers approach patients of different races (e.g., African American patients and/ or health care providers may be more likely to defer CRC screening procedures until symptoms or signs of illness develop, which may account for the higher rate of colorectal carcinoma incidence among African Americans) (ibid). The confluence of various socio-demographic factors, (income, education, presence of Medicare supplemental insurance) therefore, may also be affected by the higher prevalence of comorbid illnesses in the African American population (diabetes, high blood pressure, obesity, sickle cell anaemia, among others), and thus recommendations for CRC testing may not be delivered in the same way to this population as it is to a more highly educated, higher SES white population.

As further evidence of this trend, Green et al note that among African Americans, 21.6% of individuals 50 years of age or older had not had a FOBT within the past year, and less than half of this population had a FSIG or screening colonoscopy within the last five years, thereby underscoring the need to heighten awareness and promote the necessary nature of CRC screening examinations at regular intervals (Green et al, 2007). What has become even
more apparent, however, is the disparity in information dissemination (at the individual, physician, and institutional levels) and subsequent racial/ethnic/SES associated patient follow-through with CRC screening tests. As such, while significant advances have been made in CRC screening, and a protocol has been set forth for payment of CRC screening tests by Medicare and Medicaid Services, attention needs to be shifted back to getting patients aged 50 and over (regardless of race or SES) screened for CRC (with, as noted earlier, an annual FOBT, FSIG every five years, DCBE every five years, FSIG and FOBT every five years, and a colonoscopy every ten years). This shift must be made at the community level; with CRC screening prioritized in the same way as various vaccinations (e.g., tetanus, polio, influenza, among others) have been, in the past.

Examples of Community-Based Approaches to Increased CRC Screening

A community-based approach to CRC screening follows the conceptual framework set forth in the Health Belief Model (HBM) that explains why people engage or fail to engage in preventive healthcare actions (like CRC screening). This particular approach suggests that taking a specific health action is largely dependent upon an individual’s personal “susceptibility to the illness, the degree of severity of the consequences of contracting CRC, the health action’s potential benefits in preventing susceptibility to CRC, as well as the physical, psychological, financial and other barriers related to the advocated behaviour” (ibid, p. 207). Further, there needs to be some sort of social impetus to cue an individual to seek out CRC screening. Here, we can look at some of the barriers to seeking out CRC screening, not the least significant of which is the role of real and perceived social capital in the healthcare process.

Perceptions of social capital and the perceived “social worth” of a patient within the healthcare system has long been a source of discussion within scholarly circles, as there exist significant disparities in treatments, numbers and costs of tests ordered, and even with the degree to which a physician maintains a solid relationship with a patient that is based predominately upon the race, SES, and insurance status of that patient. To this end, issues pertaining to a patient’s race, SES, geographic region in which s/he resides, type of occupation in which the patient works, and even the type of health insurance that a patient has (e.g., private health insurance versus Medicare or Medicaid) all have been found to dictate the quality of care that a patient receives. With regard to CRC screening, these perceptions of social capital and perceived social worth of the patient could prove deadly for those patients whose lives are not valued as highly (by virtue of race, SES, insurance status [e.g., ability to pay whatever remains after insurance pays their part]) as those who do have access to these resources. In essence, these perceptions of social capital create anomic communities that are seemingly disconnected from the mainstream patient base. Indeed, it is these communities that require interventions with CRC screening the most. To this end, Green et al identify several “cues to action” that must occur to trigger an appropriate response to a perceived threat to one’s health (ibid).

When one thinks of “cues to action” with regard to valuable information relating to CRC screening, attention must be focused on the types of knowledge that underserved populations (e.g., poor African American) receive with regard to screening practices. Studies have shown that impoverished communities of colour over the age of 50 have not received adequate information to make informed decisions for themselves regarding CRC testing. As such, low income minority women are more likely to identify barriers to CRC screening than are their male counterparts, but less than 50% of Green’s sample passed a basic CRC screening knowledge test (ibid), which gives further fuel to the argument that as one’s educational level increases, their likelihood of being screened appropriately for CRC also
increases (e.g., the threat of CRC decreases because of perceived compliance with screening protocols).

**Interventions**

Given the community-based approach described above, several interventions are useful in protecting low-income racial and ethnic minorities from CRC. First, educational programs should be directed at correcting the misconception that CRC is usually fatal at diagnosis. This misperception, alone, may be responsible for large numbers of racial and ethnic minorities not volunteering to undergo CRC screening for fear of the “unknown” or that they will “lose their colon” if the results are positive for CRC. Further, educational programs should address how CRC screening is completed (and how it differs from previously painful screening procedures that used to use rigid nonflexible instruments) (ibid, p. 214). Further, given that fear is as much of a detractor as it is a motivator, community CRC interventions need to focus on the importance of early detection and on the role of positive outcomes (e.g., pre-cancerous adenomatous polyps can be removed during routine FSIG and colonoscopies thereby reducing significantly the likelihood that the patient will develop CRC).

Further interventions need to be made at the health professional level, as when health professionals are kept abreast of the latest official CRC screening recommendations, they can then pass this information on to their patients. Moreover, the literature on possible interventions into CRC screening note that advanced practice nurses should “be encouraged to incorporate current recommendations for CRC screening into routine medical exams,” so that CRC screening is not viewed as an “add-on,” but as part of a regular check-up examination (ibid), and that physicians should promote medical office visits as actual opportunities to provide CRC screenings (which, in turn, would help to increase CRC screening rates, while simultaneously educating patients about the importance of CRC screening to detect colon cancer early so that it can be treated) (McAlearney et al, 2007, p. 397). Further trends have emerged indicating that if one’s regular treating physician has a “good bedside manner” and can discuss CRC screening using terms that a lay person can understand, compliance with CRC screening protocols are likely to be higher (Starr, 1984). This fits with Eliot Friedens’s (1988) notion of how medical personnel need to interact with their patients. That is, Friedsen posits that physicians not take on a God complex as though the physician knows “everything,” but, instead, place the agency back into the hands of the patient who is well armed with information to make the best decisions regarding CRC screening for him or herself. In so doing, patients are not merely passive followers of protocol and policy, but become active actors in their own overall healthcare.

**Applying the Social Ecological Framework to CRC Screening**

The Social Ecological Framework (SEF) was posited by McLeroy et al (1998) as a means for understanding health-related behaviours at various levels in much the same way that Anthony Giddens views his iterative concept of structuration; namely, that individuals influence and shape their environment as the environment influences and shapes individuals. Given that McLeroy’s SEF allows for interventions that alter individual beliefs to improve behaviour, the environment to reinforce healthy behaviours, and the environment to improve individual health beliefs, one can translate this model into a four-tiered set of concentric circles (as depicted in Figure 1) in which individual health behaviours are at the centre of the model (because individual beliefs about CRC or any other health issue will govern individual behaviours in that same realm, p. 352).
As Figure 1 depicts further, the ring around the centre ring is interpersonal - social networks and support - and represents the social network to which the patient belongs, and whether s/he would have support for undergoing even base-level FOBT CRC screening. These two initial levels represent the key areas in which individual agency play a part in determining whether an individual will not only engage in a health promoting behaviour (like CRC screening), but will also have the support network of family and friends within which to deal with the realities of what the screening might reveal. It is at these two perfunctory levels that the Health Belief Model (HBM) plays a significant role. When thinking about the HBM, it has become clear that individuals move between subjective and objective risks as they evaluate the risk/benefit expectancies, paying particular attention to perceived susceptibility, perceived severity, perceived benefits, perceived barriers, self-efficacy, and cues to action in terms of the likelihood of changing one’s behaviour (in this case, opting to follow through with recommended CRC screening). The third concentric circle represents that of one’s community or place characteristics. It is here that most interventions toward increasing CRC screening need to focus because CRC screening is not solely an individual phenomenon, and it is not solely a societal trend; rather CRC screening must be instituted and promoted at the meso (community) level in such a way as to be at the educational level and language of the residents residing in the target community. Here, one may extrapolate a bit further that in order to instill trust in a predominately minority and lower SES community, it is helpful further for the health practitioners to not only practice medicine in the community, but to also live there, speak the same language, and look the same (e.g., be of the same race or ethnicity) as their patient base (that is, there is much to the social psychological theories that maintain that one will trust someone of their own race if that person is advocating a potentially scary screening test (e.g., CRC screening), than if a white physician is recommending that same test to a person of colour for whom English is not a first language) (Heirich, 1997). The
fourth, and final, concentric circle represents the population. It is at this level that the distribution of power and resources are doled out, and thus it is also at this level that certain forces toward social change (within the social ecological model) need to be focused.

**Application of the SEM to CRC Screening**

CRC screening has long been associated with lower CRC morbidity and mortality rates among the white middle to upper middle class population, but knowledge and consent to screening among minority and lower SES groups varies greatly by educational level and outreach to these communities at risk. Indeed, minority and lower SES groups are at greater risk for CRC because they do not have the same continuity of care that is documented among their white counterparts. Thus, established research by noted gastroenterologists and sociologists of health and illness shows that the SEM is an appropriate model for outlining how various factors at the individual, interpersonal, community, and population level impact CRC screening and interventions aimed at increasing CRC screening.

At the individual and interpersonal levels, it is evident that clear-cut educational materials about the perceived benefits of CRC screening, together with “testimonials” from members of the community may be enough to strengthen individual trust in the medical system. This suggestion is strengthened by Becker et al’s qualitative findings, as they note that participants in focus groups “agreed that CRC is not on the public’s radar screen” (Becker, 2000, p. 271). Further, respondents in Becker’s study noted astutely that, “(j)ust the mention of “breast cancer” or “prostate” once made people squeamish…. so will publicity about CRC make it easier to say “rectum” or “colon””(ibid). Here we can focus on mapping social integration into the realm of CRC screening, and focus on how individual and interpersonal social network ties may be strengthened by using lay health advisors who teach about the importance of the life-saving CRC screening. After all, if we alter the practices of key individuals in a social network, the norms of that social network become altered, as well. At the individual and interpersonal levels, stressing that CRC is 100% preventable if the guidelines set forth by the US Preventive Services Task Force (in conjunction with the major health organizations governing gastroenterology) are met; namely, an annual FOBT, a FSIG every five (5) years, a DCBE (every five years), a FSIG and a FOBT (every five (5) years) and a colonoscopy (every ten (10) years) will set in motion a cycle by which patients will begin to see CRC screening as routine as moderating food choices and checking one’s blood sugar (if diabetic). Further, education (in multiple languages) about the symptoms of CRC, and knowing what might be problematic issues (if experienced) may also help to break down some of the barriers to CRC screening (by increasing an individual’s sense of self-efficacy and ownership in their own healthcare process), especially if the perceived barriers to care are taken away and are replaced by health care providers who are well versed in the community that they serve. If this can be accomplished at the individual and interpersonal levels in US society, it is quite likely that late stage CRC diagnoses will begin to decline among minority and lower SES individuals.

At the community and population levels, research in public health has indicated that the confounded issues of racism, classism, and lower educational levels has led to a lower rate of CRC screening tests, and thus a higher rate of CRC diagnoses at later stages of the disease. Further, quantitative students also suggest that “older Americans are more poorly informed about CRC screening and have limited interaction with their providers or peers about a major cancer killer in the United States” (ibid, p. 276). Once again, the question of logistics and where and how individuals can get the necessary information about CRC screening comes into play. Removing the issue of SES in the CRC screening process (by having Medicare and Medicaid cover 100% of the screening costs) represents one way that
the community may be reached without there being a stigma surrounding “inability to pay” for expensive screening tests. Cooper et al document this issue by stating that racial disparities exist not only in the use of CRC procedures, but also in the indications for such testing. As such, these disparities are consistent with delays in CRC diagnosis in minority populations (with different tests being ordered for racial and ethnic minorities than for whites), with such a rationale being proffered because there are comorbid illnesses in African Americans that confound the testing schemata (Cooper et al, 2003). Removing the socioeconomic/insurance component, however, should serve to equalize the “playing field” and enable CRC screening early and often for all segments of the US population. The remaining factor that needs to be addressed, however, is trust in the medical system.

One of the key interventions at the population level has to be re-instilling trust in the medical system for all people, but especially for racial and ethnic minorities. Distrust in the medical system and fear that patients are being led astray for physician’s own gain continue to be at the forefront of the African American mindset, which remains reminiscent of such events as the Tuskegee Experiment (syphilis) in which African American men were unknowingly infected with syphilis without informed consent as a means of social eugenics (http://www.cdc.gov/tuskegee/timeline.htm), family planning and involuntary sterilization, and the participation of the medical system in the justification of racism and discrimination in society. Further, Becker et al (2000) maintain that the “low visibility of CRC compared to other health issues, such as breast cancer, in the mass media may contribute to the perception that CRC is either unimportant, untreatable, or a “private” disease” (p. 273). As such, positive change must be instituted over time and with more positive interactions with the healthcare system than what has occurred in the past. At the population level, more regulation is needed to ensure that those who interact with the medical system for CRC screening are getting the tests for which they consented. Regaining trust at the population level will take time, and, indeed, it is the test of time that will determine whether CRC screening for ALL segments of society can reduce the high CRC morbidity and mortality rates that currently exist among minority populations.

CONCLUSION

While signing up for a FBOT, FSIG, or a colonoscopy CRC screening test may not be the most exciting thing that the average American does every few years, research has shown that these tests are a necessary evil, and that with the screening, can ensure that CRC morbidity and mortality rates decline over time. In order to ensure that members of all populations are reached, however, ardent efforts need to be made to reach racial and ethnic minorities in their communities (whilst remaining cognizant of cultural sensitivities relating to consenting to these tests) in their language(s), and with respect to their unique cultures and customs. Reaching out to these communities in these ways represent a series of “first steps” toward eradicating CRC as a major “killer” of racial and ethnic minorities, that when coupled with coverage through Medicare and Medicare (to cover the costs of CRC screenings 100%) should help to decrease the racial and ethnic disparities in CRC morbidity and mortality. Clearly, however, further research is needed on how to combat issues of lower SES and the impact of that on comorbid diagnoses (e.g., diabetes, obesity or being in a structural position wherein processed foods are more affordable than fresh fruits and vegetables) that can also affect CRC screening and diagnoses.
REFERENCES


http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics

http://www.cdc.gov/tuskegee/timeline.htm


http://www.irp.wisc.edu/faqs/faq1.htm


**Negative Social Exchanges, Acculturation-Related Factors, and Mental Health among Asian Americans**

*Wei Zhang*

University of Hawaii at Manoa, Honolulu
weizhang@hawaii.edu

**ABSTRACT**

For people influenced by collectivistic cultures, the encounter of negative social exchanges may be particularly detrimental as harmonious and balanced interpersonal relationships are highly valued. Focusing on Asian Americans, this study examines the relative importance of three domains of negative versus positive social exchanges on psychological distress, and how acculturation-related factors (i.e., English proficiency and nativity) moderate the association between negative social exchanges and psychological distress. Results suggest that three domains of negative social exchanges (family cultural conflict, negative interactions with relatives, and negative interactions with friends) are related to distress but at varying degrees, with the effects of family cultural conflict being the most salient. Second, for some negative social exchanges, their effects on distress are greater than the effects of parallel positive social exchanges. Most importantly, the relationship between negative social exchanges and distress conditions on acculturation factors: The U.S.-born (compared to the foreign-born) respondents are more responsive to negative interactions with friends; individuals with poor/fair English (compared to individuals with good/excellent English) are more vulnerable towards family cultural conflict. Findings imply the importance of various dimensions of negative social exchanges, acculturation, and their interactions in understanding the mental health of Asian Americans.

**Key words**: Negative Social Exchanges, Acculturation, Mental Health, Asian Americans

**INTRODUCTION**

The salutary effect of social relationships on individual health has been well documented (Berkman et al. 2000; Cohen 2004; Krause 2006). However, not all social relationships are pleasant. Over the past two decades, a growing literature has begun to disclose the adverse effect of negative social exchanges on individual health (Finch et al. 1999; Rook 1998). According to some researchers, the deleterious effect of negative social exchanges on well-being may actually be greater in magnitude than the beneficial effect of positive social exchanges (Bertera 2005; Lincoln, Chatters, and Taylor 2003; Newsom et al. 2003; Rook 2003). These studies suggest the importance of negative social exchanges in understanding the mental health of individuals. Research along this line has been replicated in Asian countries like China (Li and Liang 2007) and Japan (Akiyama et al. 2003; Okabayashi et al. 2004), and among ethnic minorities in the United States such as African Americans (Lincoln et al. 2003).

Despite these efforts, very few studies have focused on Asian Americans in general—an under-represented but very important ethnic minority in the United States. Negative social exchanges may be particularly detrimental to Asian Americans given their unique cultural background. According to Taylor and colleagues (2004), norms, values, and expectations on interpersonal relationships tend to differ significantly across cultures. While individuals are socialized to encourage and maintain their independence in individualistic cultures,
individuals in collectivistic cultures are often socialized to emphasize interdependent relationships and work to maintain harmony within groups (Markus and Kitayama 1991). In addition, different from Western cultures, relationships tend to be less voluntary and demand more obligations (Adam and Plaut 2003; Adam 2005), and individual needs are often subordinate to group goals in collectivistic cultures (Markus and Kitayama 1991). These cultural differences may lead to two implications for Asian Americans. First, the conflict of norms, roles expectations, and obligations resulting from the tension between preserving collectivistic traditions and assimilating into the host cultures may lead to an increasing level of negative encounters. Second, violations of harmonious relationships would be particularly detrimental for Asian Americans who, more or less, still value a holistic or balanced view of interpersonal relationships.

To meet the urgent needs of studying mental health of Asian Americans, Takeuchi and colleagues (2007) are among the first to provide national estimates on the prevalence of mental disorders among Asian Americans. They revealed that, for Asian American adults, the overall lifetime rate of any mental disorder was approximately 17.3% and the 12-month rate was 9.2%. The major objective of the current study is to expand previous focus along this line by examining the role of negative social exchanges in understanding a dimensional measure of mental health (i.e., psychological distress) among Asian American adults (who were 18 years or older), and how acculturation factors such as English proficiency and nativity (place of birth) modify this association.

BACKGROUND
Different domains of negative social exchanges and their impact on psychological distress

Negative social exchange is a multi-dimensional concept, covering social actions that are directed toward the target individual displaying negative effects such as (1) being angry or upset, (2) being overly critical and demanding, (3) showing insensitivity or omission, and (4) making goal attainment difficult (Boerner et al. 2004; Rook 1984; Ruehlman and Karoly 1991). These dimensions of social negativity can be derived from different layered domains with hierarchical order—social networks with intimate family members and relatives, and social networks with friends. According to Lin, Ye, and Ensel (1999), human beings are embedded in a nested support system: Starting from the ego, social relations extend outward to the intimate binding ties such as marital relationships, then to the intermediary bonding relations such as relative or friend social networks, and finally to the outer-most layer of belongingness such as community participation. Different layers of support demands different levels of individual input and thus may have differential health impact. In their study, they found that the inner-most intimate ties have direct and the greatest effects on distress among various layers of support structure. Given that these four major dimensions of social negativity tend to be differentially attached to the nested domains of support structure, this study applies two distinct sets of measures to gauge two generic domains of negative social exchanges: negative social exchanges with (1) relatives, and (2) friends.

This study also considers the third domain of negative social exchange—family cultural conflict, which is particularly relevant to Asian Americans who share common values such as filial piety, humility, and interdependence (Tsai-Chae and Nagata 2008). Family cultural conflict is defined as cultural and intergenerational conflict between the respondents and their families (Alegria et al. 2004). Prior studies suggest that immigrant families with traditional Asian backgrounds tend to experience greater family conflict or dysfunction than other ethnic minorities (Lee 1997; Ying and Chao 1996) because of the intergenerational
discrepancies in values and lifestyles due to dissonant acculturation (Portes 1997; Tsai-Chae and Nagata 2008). For instance, values such as family harmony and respect for older adults are highly appreciated in Chinese culture and Chinese persons expect to depend on their family in old age (Jackson and Howe 2004; Yang 1965). So the encounter of negative interactions within a family setting, which violates the widely accepted social norms, often leads to psychological distress and negative evaluation of life for Chinese elders (Ying and Zhang 1995). Collectively, this study focuses on generic negative social exchanges (such as negative interactions with relatives and friends) as well as Asian culture-oriented negative social exchange (such as family cultural conflict). The following varying effects hypothesis will be tested in this study:

Varying Effects Hypothesis: Among Asian American adults, all three domains of negative social exchanges have impact on psychological distress, but their effects tend to vary according to their relative importance to individuals.

The relative importance of negative versus positive social exchanges

Several theories are put forth explaining why negative social exchanges have more potent effects in determining individual psychological well-being (Krause 2007; Rook 1990). First, according to the basic tenets of the expectancy theory (Olson, Roese, and Zanna 1996), interpersonal unpleasantness violates widely shared expectations that friends and family tend to be supportive. The overtly negative interaction is a counter-normative behavior, so when it arises, it often surprises the recipient and threatens an individual’s sense of meaning, predictability, and order, which may lead to severe mental health consequences. Second, unpleasant exchanges with others may also challenge fundamental notions concerning the self. As suggested by Cooley’s (1902) notion of “looking-glass self”, feelings about the self are strongly influenced by feedback from significant others. When such feedback is perceived to be negative, the recipient’s psychological well-being will be greatly undermined because of the erosion of a sense of self-worth. Accordingly, the relative importance hypothesis is presented as follows:

Relative Importance Hypothesis: The effects of negative social exchanges on psychological distress tend to be greater than the effects of positive social exchanges among Asian Americans.

IMMIGRATION-RELATED FACTORS, NEGATIVE SOCIAL EXCHANGES, AND PSYCHOLOGICAL DISTRESS

Acculturation is a multidimensional construct and its relation to mental health is complex. Some studies reported higher rates of psychological distress among immigrants compared to the host country population (Bengi-Arslan, Verhulst, and Crijnen 2002; Khavarpour and Rissel 1997; Miyasaka et al. 2002), whereas others on Hispanic immigrants reported otherwise (Ortega et al. 2000; Vega et al. 1998). These inconsistent findings suggest that some dimensions of acculturation such as language assimilation into the host country and the resulting social integration may have salutary effects on mental health (Diwan 2008); other dimensions such as gradually relinquishing one’s native cultures like strong familial and ethnic ties, may have detrimental mental health consequences (Vega et al. 2004).

Acculturation may influence the characteristics of social connections and indirectly impact mental health. While immigrants with lower levels of acculturation may primarily rely on their family for support, their counterparts may develop richer networks outside the family domain. However, having more contacts is not necessarily a blessing. Studies have started to show that the more contacts people have, the more conflicts and frustrations they tend to
experience (Akiyama et al. 2003). Meanwhile, individual’s perception, sensibility, and tolerance towards negative encounters also vary according to their experiences and expectations, all of which vary by levels of acculturation. Compared to immigrants with higher levels of acculturation, their counterparts may be less sensitive to negative interactions while experiencing other more significant stressors like discrimination and language barriers. Generalizing these arguments, the differential exposure/reporting hypothesis can be proposed:

**Differential Exposure/Reporting Hypothesis:** Compared to Asian American adults with lower levels of acculturation indicated by foreign-born and poor/fair English ability, Asian American adults with higher levels of acculturation indicated by U.S. born and good/excellent English ability tend to report more negative social exchanges.

Most importantly, domains of negative social exchanges may interact with acculturation-related factors to impact the mental health of Asian Americans. Studies have begun to document the contingency effects of age and life stressors. August, Rook, and Newsom (2007) found that negative social exchanges and stressful life events jointly affect emotional distress. Li and Liang (2007) showed that the deleterious effects of negative interactions on depression are more for the old-old Chinese than for the young-old Chinese. To explain this age difference, they argued that social exchanges may take on greater meaning as people age. This indicates that negative social exchanges are more likely to affect those who highly value the importance of particular types of social exchanges. For Asian Americans with lower levels of acculturation, family-oriented and collectivistic values are more appreciated; thus, family cultural conflict will be more detrimental. For those with higher levels of acculturation, beliefs and values from the host culture may be increasingly emphasized; thus, negative interactions with peers outside family domain may be more harmful. Summarizing this line of argument, the differential impact hypothesis can be derived:

**Differential Impact Hypothesis:** The relationship between negative social exchanges and distress varies according to acculturation-related factors: While negative interactions with friends are more harmful for the U.S.-born and individuals with good/excellent English, family cultural conflict and negative interactions with relatives tend to be more harmful for the foreign-born and individuals with poor/fair English. The above theoretical framework was summarized in Figure 1.
METHODS
Data
The 2002-2003 National Latino and Asian American Study (NLAAS), a nationally representative household survey of Latino and Asian Americans, was used to test the aforementioned hypotheses. This survey used a stratified area probability sample design and involves three major steps of sampling (Heeringa et al. 2004). The first step was the core sampling: city or contiguous census blocks were selected according to population density; then, housing units were sampled within each block and then one adult was sampled within each selected housing unit. The second step was the supplementary sampling: census blocks with greater than 5% of the target population such as Asian households were oversampled. In order to further enlarge the sample size, the third step was applied to recruit the secondary respondents from previously sampled households. The face to face interview was administered by bilingual lay interviewers, and respondents were allowed to choose among available languages such as English, Chinese, Vietnamese, or Tagalog.

This study focused on Asian Americans with three major national origins (Chinese, Filipino, and Vietnamese) and “Other Asian Americans” such as South Asians, Japanese, Koreans, and others. A total of 2,095 Asian Americans were recruited, including 1,611 primary respondents and 484 secondary respondents. The weighted response rates for both primary and secondary respondents were over 69%. In this analysis, there are no missing data for gender, age, marital status, parental status, education, household income, and employment status. Less than 1% of the data were missing for immigration-related factors. Less than 2% of the data were missing for indices of positive and negative social exchanges and psychological distress. Any valid index is computed for anyone who answered at least half of the items used for that index. After listwise deletion of missing cases, the analytical sample of this study was reduced from 2,095 to 2,076.

The weighted statistics show that more than half of the respondents were female (52.6%)
and most of them were married (68.8%) and employed (63.9%). The percentages of respondents who were not in the labor force and unemployed were 29.7% and 6.4%, respectively. Approximately 50% of the sample reported living in the U.S. for at least 11 years and more than three fourth of the sampled respondents (76.2%) were foreign-born. In terms of education and income, around 68% of the respondents reported having at least some college level of education and over 40% having an annual household income of at least $75,000. Almost 29% of the respondents were Chinese, 13% Vietnamese, 22% Filipino, and 37% other Asian Americans.

Dependent variable

The Kessler Psychological Distress Scale (K10) was used to measure psychological distress. The K10, consisted of 10 questions, is considered a simple and valid measure of mental health (Furukawa et al. 2003) and has been used to gauge the mental health of Asian Americans in previous studies (Walton and Takeuchi 2010). Respondents were asked to indicate frequency of incidents (from 1=all of the time, 2=most of the time, 3=some of the time, 4=a little of the time, and 5=none of the time) that they had experienced feelings of depression and anxiety (e.g., tiring out, nervousness, hopelessness, restlessness, depression, sadness, worthlessness, and everything being an effort). All items were reversely coded such that high scores reflect higher levels of distress. The average scale, psychological distress, ranges from 1 to 4.4 and demonstrates a strong internal consistency as the alpha reliability is .88.

Independent variables

Negative social exchanges, the independent variable of major interest, was measured by three average indices—family cultural conflict, negative social exchanges with relatives, and negative social exchanges with friends, with high scores reflecting high levels of negative social exchanges. To facilitate comparisons, the parallel indices of positive social exchanges were included: family cohesion, social support from relatives, and social support from friends. All three pairs of indices were standardized so that their relative effects on psychological distress can be compared.

Family cultural conflict is a five-item-index measuring cultural and intergenerational conflict between respondents and their families. Respondents were asked to indicate frequency of incidents (1=hardly ever or never, 2=sometimes, 3=often) of cultural conflict with their families such as interference with personal goals, arguments with family members due to different belief systems, and the breakdown of family unity, etc. These individual items were drawn from a subscale of the Hispanic Stress Inventory (HSI) (Cervantes, Padilla, and Salgado de Snyder 1991). In the NLAAS, five items from the Family/Culture Stress subscale of the HSI were selected to develop the family cultural conflict scale for Latinos and Asian Americans. Among 2,076 valid Asian American respondents, all items making up family cultural conflict loaded on a single factor above .66 and the alpha reliability is .76.

Family cohesion is defined as affective involvement or emotional bonding among family members (Olson 2000). It measures respondents’ sense of family and emphasizes the importance of family togetherness. According to Olson (2000), family cohesion is a continuum and it ranges from “disengaged” to “enmeshed.” At one of the extreme ends—disengagement, “family members do their own thing, with limited attachment or commitment to their family members” (Olson 2000:145). Given that family cultural conflict is an index composing measures gauging disengagement and lower levels of commitment among family members, it can be considered as an approximate index that parallels to family cohesion. In this study, family cohesion is obtained through the sum of a three-item subscale from the
family cohesion scale developed by Olson (1986). Respondents indicate how strongly (from strongly agree (1) to strongly disagree (4)) they agree with a variety of statements regarding their family: (1) family members like to spend free time with each other, (2) family members feel very close to each other, and (3) family togetherness is very important. Response categories were reversely coded such that higher scores reflect greater levels of family cohesion. All items loaded on a single factor above .84 and the alpha reliability is .84. Negative social exchange with relatives is a two-item-index, which is consistent with some of the previous studies (Ellison et al. 2009). It measures how often (1=never, 2=rarely, 3=sometimes, 4=often) relatives made too many demands on and argued with the respondents. All items loaded on a single factor above .83 and the alpha reliability is .56. The index of negative social exchanges with friends consists of two parallel items in which the word “relatives” was replaced with “friends.” These two items loaded on a single factor above .83 and the alpha reliability is .54.

Relative and friend support were measured by three items, which assessed respondents’ ability to rely on extended family or friends for emotional support (Mulvaney-Day, Alegria, and Sribney 2007). To measure relative support, respondents were asked: (1) how often they talk on the phone or get together with relatives, (2) how much they can rely on relatives for help with serious problems, and (3) how much they can open up to relatives and talk about their worries. All items loaded on a single factor above .62 and the alpha reliability is .68. The index of friend support consists of three parallel items in which the word “relatives” was replaced with “friends.” The items loaded on a single factor above .66 and the alpha reliability is .75.

Besides positive and negative social exchanges, this study also examined the moderating effects of two acculturation factors: nativity and duration of residence (U.S.-born; immigrant, duration 0-4 years; immigrant, duration 5-10 years; and immigrant, duration 11 years or more), and English proficiency. English proficiency was measured using a mean index (mean=2.80, SD=1.03, range=1-4) and measured how well (from poor (1), fair (2), good (3), to excellent (4)) respondents spoke, read, and wrote English. This index was dichotomized to contrast respondents with good/excellent English (scored 3 and above) to respondents with poor/fair English skills (scored below 3). In this sample, approximately 76% reported being foreign-born and 63% having good/excellent English skills.

This study controls for education (less than high school, high school, some college, and college and more), annual household income (in dollars), employment status (employed, unemployed, and not in the labor force), age (in years), gender (female: 0=male, 1=female), marital status (married/cohabiting, divorced/separated/widowed, and never married), parental status (Children under 17 years at home: 0=no children at home, 1=children at home) and national origin (Vietnamese, Chinese, Filipino, and Other Asian Americans).

RESULTS

Associations of acculturation-related variables with positive and negative social exchanges and distress

Table 1 documents the mean values of positive and negative social exchanges and distress by acculturation-related factors. Results showed that nativity and duration of residence are significantly related to social exchanges and distress. The U.S.-born reported the lowest mean value of family cohesion, the highest mean values of relative and friend support, and the highest mean values of negative interactions with relatives and friends. Interestingly, they reported relatively lower level of distress. In the multivariate analysis (Tables 2 and 3),
nativity and duration of residence was dichotomized to contrast the U.S.-born with the foreign-born only. English proficiency is also significantly associated with most indices of social exchanges and index of psychological distress. Respondents with good/excellent English ability were more likely to report higher mean levels of negative social exchanges with relatives and friends, higher levels of relative and friend support, but lower levels of family cohesion and distress. Collectively, the U.S.-born and individuals with better English abilities tend to report (1) less family cohesion and family conflict, (2) more social support from relatives and friends as well as more negative exchanges with relatives and friends; and (3) lower levels of psychological distress. In this sense, the differential exposure/reporting hypothesis is partially supported. This finding suggests that Asian Americans with higher levels of acculturation may form relationships that lead to more support and more conflict, which might be an interesting and unique Western form of social bonding.

**Table 1. Mean Levels of Social Exchanges and Psychological Distress by Age and Acculturation Factors among Asian Americans**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Family cohesion</th>
<th>Family cultural conflict</th>
<th>Support from relatives</th>
<th>Conflict with relatives</th>
<th>Support from friends</th>
<th>Conflict with friends</th>
<th>Psychological distress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acculturation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S.-born</td>
<td>-.32</td>
<td>-.12</td>
<td>.39</td>
<td>.20</td>
<td>.45</td>
<td>.11</td>
<td>-.06 (.04)</td>
</tr>
<tr>
<td>0-4 years</td>
<td>.12 (.05)</td>
<td>-.05</td>
<td>-.05</td>
<td>-.12</td>
<td>.04</td>
<td>.06</td>
<td>.01 (.05)</td>
</tr>
<tr>
<td>5-10 years</td>
<td>.25 (.04)</td>
<td>.07</td>
<td>-.42</td>
<td>-.21</td>
<td>-.42</td>
<td>-.09</td>
<td>.17 (.07)</td>
</tr>
<tr>
<td>&gt;11 years</td>
<td>.06 (.03)</td>
<td>.05</td>
<td>-.07</td>
<td>-.01</td>
<td>-.12</td>
<td>-.05</td>
<td>-.01 (.03)</td>
</tr>
</tbody>
</table>

| English         |                 |                          |                        |                        |                     |                      |                       |
| Poor/fair       | -.07            | -.00                     | .20                    | .15                    | .27                 | .15                  | -.07 (.03)          |
|                 | .11 (.03)       | .00                      | -.34                   | -.25                   | -.46                | -.25                 | .12 (.04)           |

Notes: N=2,076; Two-tailed tests: *p<.05, **p<.01, ***p<.001, for significance of association of each variable with the normalized social exchange indices and normalized index of psychological distress; Indicators of negative social exchanges are family cultural conflict, conflict with relatives, and conflict with friends; Indicators of positive social exchanges are family cohesion, support from relatives, and support from friends; Standard errors are shown in parentheses.

**Effects of positive and negative social exchanges, and acculturation factors on distress**

Table 2 presents the regression coefficients for four ordinary least squares (OLS) regression models. The first univariate model only included different dimensions of social exchange. Models 2-4 adjusted for demographics, socioeconomic characteristics, and acculturation factors in a sequential manner to see if the focal relationships in model 1 remain significant and determine the extent of the coefficients (associated with social exchanges) modifications induced by the adjustment.

Positive and negative social exchanges, the focal variables of this study, were added into Model 1 of Table 2. As expected, indices of negative social exchanges were positively associated with distress, whereas indices of positive social exchanges were negatively associated with distress. Besides, the effect of family cultural conflict (b=.144, p<.001) on distress is almost four times greater in magnitude than the effect of family cohesion (b=—.039, p<.001). Moreover, among three domains of negative social exchanges, the effect of family cultural conflict (b=.144) on distress is the most salient, followed by the effects of
negative interactions with relatives (b=.019), and negative interactions with friends (b=.014). When an individual pair of social exchanges is put in the model, all of them are significant at the .001 levels and all the effects of negative interactions are greater than the effects of positive social exchanges.

Including demographics into Model 2 led to several coefficient changes associated with social exchanges. For instance, both the magnitude and significance level of family cohesion coefficient dropped (from b=−.039, p<.001 to b=−.025, p<.05), suggesting that its effect on distress could be partially mediated by demographic factors such as gender and marital status. Conversely, the effect of friend support became more significant and pronounced in Model 2. This finding suggests that when keeping all demographics as constant, individuals with more friend support tend to report significantly lower levels of distress. In other words, the positive effect of friend support on mental health was suppressed, to some extent, due to the demographic disparities among respondents. Despite these changes, all the coefficients associated with social exchange remain or become more significant in Model 4 after adjusting for socioeconomic and acculturation-related factors. Except for the pair of social exchanges with friends, the effects of negative social exchanges on distress are all greater in magnitude than the effects of positive social exchanges in Model 4. Findings also suggest that females (compared to males), the never married (compared to the married), and the Chinese (compared to the Vietnamese) reported higher levels of distress, whereas individuals with good/excellent English skills reported significantly lower levels of distress.

Collectively, these results suggest that all three domains of negative social exchanges have effects on psychological distress, but their effects vary. Therefore, the varying effects hypothesis is largely supported by the data. Findings also indicate that the effects of negative social exchanges on distress tend to be greater than the effects of positive social exchanges. This is especially true when individual pair of social exchange was added into the full model separately. Hence, the relative importance hypothesis is partially supported by the data.
Table 2. Estimated Regression Coefficients for Dimensions of Social Exchange (Model 1), Demographics (Model 2), Socioeconomic Characteristics (Model 3), and Acculturation Factors (Model 4) on Psychological Distress among Asian Americans.

<table>
<thead>
<tr>
<th>Dimensions of Social Exchanges</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family cohesion</td>
<td>—.039 (.011)***</td>
<td>—.025 (.011)***</td>
<td>—.024 (.011)***</td>
<td>—.027 (.011)***</td>
</tr>
<tr>
<td>Family cultural conflict</td>
<td>.144 (.011)***</td>
<td>.143 (.011)***</td>
<td>.143 (.011)***</td>
<td>.140 (.011)***</td>
</tr>
<tr>
<td>Positive support from relatives</td>
<td>.019 (.011)***</td>
<td>.023 (.011)***</td>
<td>.025 (.011)***</td>
<td>.026 (.011)***</td>
</tr>
<tr>
<td>Negative interaction with friends</td>
<td>—.025 (.011)***</td>
<td>—.040 (.012)***</td>
<td>—.037 (.012)***</td>
<td>—.032 (.012)***</td>
</tr>
<tr>
<td>Demographics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>.000 (.001)</td>
<td>.000 (.001)</td>
<td>.000 (.001)</td>
<td>.000 (.001)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>.050 (.020)***</td>
<td>.047 (.020)***</td>
<td>.043 (.020)***</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/cohabiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>.010 (.036)</td>
<td>—.011 (.037)</td>
<td>—.005 (.037)</td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>.094 (.029)***</td>
<td>.073 (.031)***</td>
<td>.078 (.031)***</td>
<td></td>
</tr>
<tr>
<td>Parental status (no children at home)</td>
<td>—.026 (.023)</td>
<td>—.029 (.023)</td>
<td>—.028 (.023)</td>
<td></td>
</tr>
<tr>
<td>National origin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vietnamese</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Filipino</td>
<td>—.001 (.035)</td>
<td>.013 (.036)</td>
<td>.042 (.037)</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>.084 (.033)</td>
<td>.097 (.033)</td>
<td>.102 (.033)</td>
<td></td>
</tr>
<tr>
<td>Other Asian Americans</td>
<td>.019 (.032)</td>
<td>.034 (.033)</td>
<td>.056 (.034)</td>
<td></td>
</tr>
<tr>
<td>Socioeconomic Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education levels</td>
<td>—.012 (.010)</td>
<td>—.003 (.010)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household income ($)</td>
<td>—.024 (.010)</td>
<td>—.022 (.010)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment status (Employed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>.019 (.040)</td>
<td>.018 (.040)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not in labor force</td>
<td>—.027 (.023)</td>
<td>—.025 (.023)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acculturation Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nativity (U.S.-born)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign-born</td>
<td>—.005 (.025)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English proficiency (Poor/fair)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good/excellent</td>
<td>—.079 (.025)***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>1.364</td>
<td>1.291</td>
<td>1.402</td>
<td>1.420</td>
</tr>
<tr>
<td>Adjusted R²</td>
<td>.140</td>
<td>.150</td>
<td>.160</td>
<td>.160</td>
</tr>
</tbody>
</table>

Notes: N=2,076; Two-tailed tests: *p< .05; **p< .01; ***p< .001; Indices of social exchanges are normalized to have a zero mean and standard deviation of one; a reference group.

The joint effects of negative social exchanges and acculturation-related factors

After the relative importance of negative social exchanges over positive ones was identified, whether acculturation-related factors moderate the association between the negative social exchange and psychological distress was tested by adding multiplicative interaction terms into the full model (Model 4) of Table 2. The interaction between nativity and language proficiency was also tested.

Results suggest that (1) the interaction between good/excellent English and family conflict (b= —.068) is significant at the .001 levels, (2) the interaction between foreign-born and good/excellent English (b= —.228) is significant at the .01 levels, and (3) the interaction between good/excellent English and negative interactions with friends (b= —.043) and the interaction between foreign-born and negative interactions with friends (b= —.030) are marginally significant at the .1 levels. Therefore, both nativity and language appear to be important moderators.

To achieve a better understanding of the important interactions identified above, the whole sample was divided by nativity and English proficiency. For each subsample, only the adjusted main effects of the negative social exchange on distress were documented. Several
interesting patterns were summarized in Table 3. Although the effects of family cultural conflict were found to be consistently significant at the .001 levels throughout subsamples, its effects vary. The detrimental effect of family cultural conflict on distress was significantly more for individuals with poor/fair English ability (compared to individuals with good/excellent English ability). And the detrimental effect of negative social interactions with friends was only significant or greater for the U.S.-born (compared to the foreign-born). As a result, the differential impact hypothesis is partially supported by the data. The significant interaction between English proficiency and nativity suggests that the effect of English proficiency on distress is related to lower levels of distress only for the foreign-born individuals.

**Table 3. Estimated Regression Coefficients for Negative Social Exchanges and English Proficiency on Psychological Distress for Selected Subgroups among Asian Americans**

<table>
<thead>
<tr>
<th></th>
<th>Foreign-born (N=1,583)</th>
<th>U.S.-born (N=493)</th>
<th>Poor/fair English (N=770)</th>
<th>Good/excellent English (N=1,306)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative Social Exchanges</strong></td>
<td>Model 1</td>
<td>Model 2</td>
<td>Model 3</td>
<td>Model 4</td>
</tr>
<tr>
<td>Family conflict</td>
<td>.154 (.012)***</td>
<td>.165 (.019)***</td>
<td>.189 (.018)***</td>
<td>.128 (.012)***</td>
</tr>
<tr>
<td>Negative interactions with relatives</td>
<td>.014 (.013)</td>
<td>.042 (.019)</td>
<td>.002 (.021)</td>
<td>.031 (.012)</td>
</tr>
<tr>
<td>Negative interactions with friends</td>
<td>.009 (.013)</td>
<td>.041 (.019)</td>
<td>.028 (.021)</td>
<td>.005 (.012)</td>
</tr>
<tr>
<td>English proficiency (Poor/fair)</td>
<td>—.102 (.027)**</td>
<td>.084 (.070)</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Notes: N=2,076; Two-tailed tests: *p<.05; **p<.01; ***p<.001; Family conflict, negative interactions with relatives, and negative interactions with friends, are normalized to have a zero mean and a standard deviation of one; a All models are adjusted for gender, age, marital status, parental status, national origin, and socioeconomic status.

**DISCUSSION**

Focusing on Asian Americans, this study examines the relative importance of three domains of negative versus positive social exchanges on psychological distress, and how acculturation-related factors modify the association between the negative social exchange and distress. First, it was found that three domains of negative social exchange have differential impact on distress. Despite the inclusion of a wide range of confounders, the effects of family cultural conflict are consistently significant and substantial for the whole sample as well as for the subsamples. This finding suggests that family harmony might be highly valued in Asian culture, and the violation of this widely accepted norm could be particularly frustrating. Prior research has demonstrated that, for Asian Americans, family cultural conflict could be much more than daily hassles; it is often compounded by cultural differences in values and lifestyles among family members. In terms of parent-child relationship, for instance, immigrant parents tend to adopt the host culture at slower rate in comparison with their children (Portes 1997), and this dissonant acculturation might cause intergenerational cultural conflict that is hard to be resolved quickly, thus leading to family dysfunction and substantial psychological consequences for family members. In addition, the intergenerational co-residence living arrangement, which is popular among Asian families, not only increases the frequency of negative encounters, but also makes the exposure to the harmful effects caused by negative encounters long-lasting.

Second, findings of this study also add to a limited but increasing body of evidence that underscores the disproportionate effects of negative social exchanges on individual psychological status (Finch et al. 1999; Rook 1998; Newsom et al. 2003). By measuring positive and negative social exchanges simultaneously and focusing on the long neglected
population—Asian American adults, this study further confirm the possibility that the negative social exchange may be more important than the corresponding positive social exchange in understanding individual psychological distress.

This study also goes beyond the rudimentary question of the relative importance of negative social exchanges by putting this line of argument into a cultural context and examining whether and how acculturation-related factors condition the impact of negative social exchange on distress. Findings suggest that while individuals with poor/fair English skills are more vulnerable towards family cultural conflict, the U.S.-born individuals are more responsive to negative interactions with friends. A couple of speculative thoughts can be offered to explain these findings. First, both negative social exchanges and their detrimental health consequences might be a function of frequency of contacts suggested by prior research (Akiyama et al. 2003): While individuals with more social contacts such as the U.S.-born are likely to develop more psycho-social resources, they may also have increased odds of negative encounters. Sometimes, the detrimental effects of the latter are more potent and longer-lasting than the salutary effects of the former. Second, varying levels of acculturation partially explain the type of networks that individuals have access to and the degree that their networks might affect them. Acculturation can be perceived as a dynamic process involving multiple aspects or stages in which individuals adjust to the host culture (Berry 1990). At earlier stage, immigrants (especially those with poor/fair English skills) are more vulnerable to the unpleasant interactions within family, which might be the only network they have access to and care about; at later stage, they might become increasingly responsive to the negative interactions from other social networks, which they deem increasingly valuable. Nevertheless, it might also be possible that the contingency effect may be less about differential values related to the importance of family and more about what the conflict measure signifies. Among people with poor/fair English, the conflict could be more about poor communications or unable to engage with another family member's social network; whereas among those with good/excellent English, the conflict could be over more "minor" issues of acculturation or preference. In this case, the amount of conflict might be the same, but the experiences are emotionally different. Therefore, it could be possible that the interaction suggests differences in what the support/conflict variables actually measure, rather than the differential value placed on social harmony.

Finally, English-language proficiency, an important indicator of acculturation (Mouw and Xie 1999), suggests an interesting pattern in this study. Compared to Asian American adults with poor/fair English skills, their counterparts reported significantly higher levels of negative interactions with relatives and friends in the bivariate analysis, yet significantly lower levels of distress in the multiple regressions. Several explanations for this finding can be briefly discussed. Asian immigrants with different levels of English ability may have different expectations of interpersonal relationships. Those with poor/fair English, who rely heavily on their family and ethnic community for social interactions, may be more satisfied with their networks (Diwan 2008) and more tolerant for the unpleasant interactions due to lack of alternative networks. For those with good/excellent English, even trivial unpleasant interactions might be unsettling because they may feel more frustrated as a function of being less socially integrated or feel more left out of social activities (an act of omission—a specific type of negative social exchanges). In addition, language barriers may also "prevent recognition of discrimination when it occurs" (Gee and Ponce 2010:888). However, despite that individuals with good/excellent English reported more negative encounters, they enjoyed better mental health, because, for them, the deleterious effects of negative interactions on distress may be offset by the salutary effects of the enlarged interpersonal relationships and the enhanced psycho-social resources. The significant interaction between English-language
proficiency and nativity suggests that the beneficial effects of better language skills are not universal. Only the foreign-born who spoke English well are less likely to be distressed.

Findings of this study are intriguing, but several limitations need to be addressed. First, although this study identified the significant effects as well as the relative importance of negative social exchanges on psychological distress, the underlying mechanisms linking them are still unclear. One study by Schnittker (2002) reveals that Chinese immigrants who primarily use English have higher levels of self-esteem than those who primarily use Chinese. His findings suggest that psychological resources such as self-esteem could be measured and considered as potential mediators linking social exchanges, acculturation, and psychological distress. Another study by Newsom and colleagues (2005) conceptualized social exchanges as interpersonal events or stressors and examined how the appraisal process might underlie the association between social exchanges and psychological health. Their findings disclose the mediating effect of the appraisal process, which helps to explain the asymmetrical effects of negative social exchanges on psychological health. All these potential mediators should be included in future surveys to disentangle the relationship between social exchanges and psychological well-being among Asian Americans.

Second, this study only focuses on Asian American adults. It should be noted that findings may be different in younger population such as adolescents. With less age and socioeconomic variations, the relationships between negative social exchange, acculturation, and distress may be even more pronounced among adolescents. In addition, some other key aspects such as experience of adverse events in life, contextual factors such as ethnic density of the neighborhood, cultural identity, religious involvement, racism experience, and immigration history should also be considered in future surveys to further disentangle the effects of social exchange and acculturation on mental health of Asian Americans.

Finally, given that acculturation is increasingly believed to be a complex, interactive, multifaceted, and bi-dimensional process (Cabassa 2003), future studies need to move beyond the use of indirect or rudimentary indicators of acculturation such as language proficiency and place of birth by including more indicators of behavioral, value, and identity-based acculturation (Schwartz et al. 2010). Meanwhile, in order to gauge respondents’ extent of socialization within or outside their ethnic community, it will be essential for future studies to identify the ethnicity of the friends with whom individuals have experienced negative encounters. Moreover, the findings are largely based on the cross-sectional data, thus limiting our ability to address causal relationships. A mixed-method approach is also needed to disentangle various types of family conflict such as marital conflict and intergenerational conflict and examine how they interact differently with acculturation factors to affect psychological distress.

Despite these limitations, the present work is significant in at least two aspects. First, it examined three pairs of social exchange and compared the relative importance of negative social exchanges over positive ones on psychological distress. Second, it explored two acculturation factors and evaluated their differential impact on the focal relationship. Findings of this study imply the significance of the negative social exchange and the acculturation process in understanding the mental health of Asian American adults. For instance, future policy makers may consider helping younger generations of Asian Americans develop bicultural appraisal and coping strategies by efficiently integrating their ethnic (through family and community socialization) as well as non-ethnic (through school education and peer relationships) sources of social support to enhance their self-esteem and promote their psychological well-being. In a culturally diverse setting like United States, a successful
acculturation can be achieved by maintaining the state of biculturalism - the healthy balancing between culture of origin and the dominant culture of the host country.
REFERENCES


Raising the profile of 'Elder Abuse' as sociologists: a call from Richenda Power

Richenda Power

Associate Lecturer, The Faculty of Social Sciences
The Open University

richendapower@btinternet.com

18/6/2013: This article has been temporarily removed from the Journal whilst we await Legal advice on its inclusion.
Does Therapeutic Massage Support Mental Well-Being?
Joyce Cavaye

The Open University
j.e.cavaye@open.ac.uk

INTRODUCTION AND BACKGROUND

Massage therapy is defined by Vickers and Zollman (1999) as “the manipulation of the soft tissue of the body to bring about generalised improvements in health”. Massage was a traditional medical practice of many ancient cultures including that of the Chinese, Egyptians, Greeks, Hindus, Japanese and Romans. The Greek physician Hippocrates (460-377BC) advocated ‘rubbing’ and related techniques such as anointing, bathing as a treatment for stiffness. In Western cultures however, the association between massage and medicine gradually diminished as Greco-Roman practices were abandoned (Goldstone 2000). While massage continued to be a folk medicine treatment during the Middle Ages, its use by the common people ensured its separation from scientific and medical milieu. Massage was thus denigrated by the medical establishment (Goldstone 2000).

Modern therapeutic massage was developed by Henrik Ling, Sweden (1776-1839) and was used in association with exercises and specific movements (Holey and Cook 2003). Despite resistance from the Swedish medical establishment, Ling gained support from clients and physicians, who adopted his techniques and shared them with likeminded colleagues (Holey and Cook 2003). Massage was considered to be an acceptable medical therapy until the early 20th century when the focus of care moved to biological sciences (Saks 2005).

While therapists have adapted Swedish massage so as to place a greater emphasis on the psychological and spiritual aspects of treatment (Vickers and Zollman 1999), massage continues to be classified as a touch based therapy which traditionally uses a variety of strokes including effleurage, petrissage and kneading (see Sherman et al (2006) for a detailed discussion on massage techniques). Touch itself is thought to be therapeutic particularly for those who have limited opportunities for physical contact such as people without intimate friends or family or who have painful physical conditions. Various studies have shown that the simple act of reaching out and touching another person can result in physical benefits (Parachin 1991, Bredin 1999). According to Parachin (1991) one touch can soothe, comfort and convey caring in a way words never can. He claims that modern psychology and medicine are confirming what people across the centuries have intuitively known, namely the healing power of touch. O’Mathúna and colleagues (2002) on the other hand, are much more sceptical and claim that the healing power of touch is all nonsense and not yet proven.

Nowadays the practice of massage is embedded within the field of complementary or alternative medicine (CAM). CAM has been defined as “diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole or diversifying the conceptual frameworks of medicine (Ernst et al 1995). For the purposes of this commentary, CAM is defined as any treatment or therapy that is not routinely and universally available to people in the UK via the National Health Service.
In recent years there has been a marked increase in the use of CAM in the UK population (Gage et al 2009). A survey found that 10% of adults in England and Wales see a CAM therapist in any one 12-month period and 40% have used it during their lifetime (Thomas and Coleman 2004). Traditionally CAM has been practised in and delivered by the private sector. However, a small but increasing number of GPs in the UK, are practising some form of CAM and a growing number of practices are providing patients with access to certain therapies most notably through in-house provision (Lewith et al 2001, Thomas et al 2001). Thus CAM is now being delivered in conventional settings such as hospices, hospitals, clinics and health centres (Hanley et al 2003, Corbin 2005, Heller et al 2005). While massage in these settings is often practised by nurses or unpaid volunteer practitioners, an increasing number of professional therapists are now employed in NHS hospitals and GP practices (Vickers and Zollman 1999).

**USE AND EFFICACY OF THERAPEUTIC MASSAGE**

Since the early 1990s an increasing number of empirical research studies into the use and efficacy of massage have been conducted. Whilst many of these have been carried out by the medical professions, others have been undertaken by nurses and CAM practitioners. The demand for evidence-based medicine requires the integration of clinical expertise with the best available external evidence from systematic research. Thus in the last twenty years the therapeutic uses of massage have broadened and research has sought to investigate its physical, physiological and psychological effects.

Therapeutic massage is widely considered to be one of the most popular and safe CAM modalities (Watson and Watson 1997, Fellowes 2002, Cherkin et al 2003). A published review of cases reported in the literature and randomised controlled trials of massage therapy found that few reported any adverse effects (Ernst 2003). As authors of a clinical review of massage published in the British Medical Journal, Vickers and Zollman (1999) note that therapeutic massage is considered to be safe with very few adverse reactions being reported.

**Mental health, stress and anxiety**

Research has documented the trend amongst users of mental health services to move away from conventional treatment towards CAM therapies such as massage. For example, Thomas et al (2001) found that in a sample of 703 people in England, 39% of visits to a CAM therapist were for ‘stress’ or ‘relaxation’. In the USA a major survey explored the use of CAM by 9,585 people who were considered to have a ‘mental disorder’ (Unutzer et al 2000). Of these, 16.25 % of respondents reported using CAM in addition to conventional medicine in the previous twelve months. Another survey of 2055 people discovered that CAM was most likely to be used by people with self-defined anxiety attacks and severe depression (Kessler et al 2001). Nine out of every ten patients with anxiety who were under the care of a psychiatrist also used some form of CAM therapy; and six out of ten patients with depression who were being seen by a psychiatrist were also using CAM to treat their condition. These rates were the same irrespective of the socio-demographic characteristics of patients (Kessler et al 2001). Also from the USA, Russinova et al’s (2002) study of 157 people with ‘severe mental illness’ such as schizophrenia, depression and bipolar disorder provides evidence of the benefits of CAM. The authors conclude that CAM seemed to promote a recovery process beyond the management of emotional and cognitive impairments by also enhancing social or spiritual capacity and promoting the individual’s own capacity for self-functioning.
This move towards CAM therapies appears to be motivated by a general dissatisfaction with the impact of conventional medication and the lack of autonomy and choice involved in treatment programmes (Unutzer et al 2000, Heller 2005b). Massage therapy is increasingly being proposed as an alternative or supplement to pharmacological and conventional treatments to counteract mental health conditions like anxiety, agitated behaviour, depression, and to slow down cognitive decline in people with dementia. Its efficacy however, is contested.

A high proportion of the general population experience stress and anxiety and these conditions are amongst the most common reasons for patients consulting their general practitioner (GP). A small study conducted in Scotland sought to evaluate the effects of therapeutic massage on the management of stress within a GP practice population (Hanley et al 2003). The researchers wanted to compare the effects of massage with the use of relaxation tapes. Patients, drawn from those attending a stress management clinic at their local health centre, were randomly selected to one of three treatment groups. Patients in the first group received six sessions of therapeutic massage, carried out by a nurse trained in this technique. Patients in the second group were given six sessions using a relaxation tape in the surgery and those in the third group were given a relaxation tape to use at home. Data measurement and analysis tools included the General Health Questionnaire-30 (GHQ-30), the Adapted Well Being Index (AWBI); a sleep scale; general practitioner (GP) consultations for any reason in the six weeks before treatment, during treatment, and six weeks following treatment; and patient satisfaction. A total of 69 patients completed the treatment. Following completion of the treatment, the majority reported a significant improvement in their general health and well-being, less emotional disturbance, better quality of sleep and fewer visits to the GP. The authors conclude however, that despite very strong patient preference for therapeutic massage, it did not show any benefits over either a relaxation tape used in the surgery or a relaxation tape used at home.

Sharpe et al (2007) conducted a similar study with older adults living in the community that sought to assess the effects of massage therapy and compare them to guided relaxation. Over a period of four weeks adults aged 60 years and over, received either 50 minutes of massage therapy or visualisation and muscle relaxation exercises. Significant improvements were found in scores for anxiety, depression and general health. The findings suggest that massage therapy enhances positive well-being and reduces stress among older adult.

A meta-analysis of 37 research reports exploring the use of massage therapy for mental ill health was undertaken by Moyer et al (2004). They found evidence that anxiety and blood pressure levels could be reduced after only a single session of massage whereas there was no immediate effect on pain or negative mood. After a number of therapeutic interventions the evidence suggested that massage could also reduce pain levels. The most commonly reported effect was lower levels of anxiety and depression (Moyer et al 2004).

A few studies on anxiety have focused on older people living in residential and long-term care settings. One such RCT study designed by Fraser and Ross (2008) to measure the effects of back massage on anxiety levels, focused on older people living in a long-term care home. Twenty-one residents, 17 females and four males, were randomly assigned to three treatment groups which received either back massage with normal conversation, conversation only or no intervention. Anxiety levels were measured at three time points: prior to back massage, immediately following, and 10 minutes later, on four consecutive evenings. The Spielberger Self-Evaluation Questionnaire (STAI), electromyography recordings, systolic blood pressure, diastolic blood pressure (DBP) and heart rate were used as measures of anxiety. The authors found that there was no statistically significant reduction in blood
Does Therapeutic Massage Support Mental Well-Being?

pressure. There was however, an improvement in the mean anxiety (STAI) score between the back massage group and the no intervention group. Given the small size and inappropriate methodology of this particular study, these results are questionable. Verbal reports however, from the participants suggest that they found the back massage relaxing. The authors conclude that massage may be an effective, non-invasive technique for promoting relaxation and improving communication with patients and recommend that touch be encouraged in caring for the elderly (Fraser and Ross 2008). The reduction in anxiety as an outcome of therapeutic massage is confirmed by several other studies (Field et al. 1996, Mok & Woo 2004, Billhult & Maatta 2009).

Another small study by Sansone and Schmitt (2000) looked at the effects of gentle massage on two groups of elderly nursing home residents: those suffering from chronic pain and those with dementia who were anxious or agitated. The massage was given by care assistants who had been trained by a professional massage therapist. The project was divided into three 12-week phases with different staff and residents involved in each phase. At the end of each phase, anxiety and pain scores for 59 residents who completed the programme had decreased. Eighty-four percent of the care assistants reported that the residents enjoyed receiving the massage, and 71% thought this type of intervention improved their ability to communicate with the residents.

In contrast to residents of residential or long-term care, Smith et al. (1999) sought to evaluate the effects of a therapeutic massage intervention in an acute health care setting. This qualitative study included 113 hospitalised patients who received up to 4 massages during the course of their hospital stay. Although they do not say what health conditions participants experienced, the results suggested positive outcomes. The most frequently reported outcomes were increased relaxation (98%), a sense of well-being (93%) and positive mood change (88%). More than two thirds of patients attributed enhanced mobility, greater energy, increased participation in treatment and faster recovery to the massage therapy. Thirty-five percent stated that benefits lasted more than one day. The study supported the value of this hospital-based massage therapy programme and uncovered a range of benefits of massage therapy for hospitalised patients that the authors claim should be studied further.

In relation to the effects of massage on dementia, Hansen et al. (2006) provide an online review of research on the use of massage for this condition. They critically examined a total of 18 studies of the effects of massage interventions but felt that the majority were too small to provide adequate evidence. They considered only two were of sufficient methodological rigour to provide reliable evidence. They concluded that the small amount of evidence currently available is in favour of massage and touch interventions for people with dementia, but is too limited in scope to allow for general conclusions. They claim that further, high-quality randomised controlled trials are required. Massage therapy has also been used successfully for other conditions such as eating disorders (Hart et al. 2001), migraine (Lawler and Cameron 2006) and non-migraine headaches (Quinn et al. 2002).

Massage is claimed to reduce stress and anxiety, insomnia and tension and aid relaxation, by a combination of mechanical, neural, chemical and psychological factors (Cochran-Fritz 1993). However, some commentators contest this by claiming that the basis of positive outcomes is entirely due to therapeutic relationships rather than the effect of any particular therapy (Mitchell and Cormack 1998, Thorlby and Panton 2002, Stone and Katz 2005). Lambert and Barely (2002) maintain that certain factors within the therapeutic relationship can influence client outcome. They categorise these into four areas: extra-therapeutic factors, expectancy effects, specific therapy techniques and common factors. They claim that
what they term ‘common factors’ such as empathy, warmth and the therapeutic relationship have been shown to correlate more highly with client outcome than any specialised treatment intervention. Thus Lambert and Barely (2001) conclude that all therapeutic encounters are interpersonal processes in which a main curative component is the nature of the underpinning therapeutic relationship.

Conclusion

Does massage therapy support mental well-being? This commentary has considered studies that used different research methodologies to explore the use and efficacy of massage therapy. It has included RCTs, surveys and qualitative research. Despite the different research methodologies applied, the literature suggests that massage therapy is a relatively safe intervention with no significant adverse effects being reported. It can be perceived as a physical or a psychological therapy. These studies however, do not explain in any great detail the interplay of neural, chemical, psychological or interpersonal factors, variables which would surely impact upon any study whatever the methodology used.

Critics claim that positive outcomes are due solely to the interpersonal nature of therapeutic relationships. Yet despite the fact that massage therapy is a treatment that relies on interpersonal relationships, there is a paucity of research that has tried to explore or measure the kind of psychological interactions that take place between the recipient and provider. Is it possible that massage therapy may produce benefits in multiple ways with specific factors and commonalities each having a role to play, but with each having different meanings for recipients? Or alternatively, is massage effective simply because it is a more accessible form of therapy and one where feeling valued is as important to the client as being ‘rubbed’?
REFERENCES


Does Therapeutic Massage Support Mental Well-Being?


Book Review

Edmonds, Alexander

Pretty Modern: Beauty, Sex, and Plastic Surgery in Brazil
ISBN: 978-0-8223-4801-6
352pp

Reviewer: Aoife McKenna
University of Edinburgh, UK

Edmonds’ ethnography ‘Pretty Modern’ deals with the often-underestimated issue of cosmetic surgery in Brazil. In it, Edmonds attempts to situate plastic surgery against larger changes in female sexuality and reproduction. The central theme focuses on the relationship of beauty to social conflicts in modernity. He analyses how beauty becomes a paradoxical “problem” in modernity, i.e. how women become ‘subjects asserting sexual rights and control over reproduction’, at the same time that the female body is also ‘turned into an object of a new sexual culture’, becoming eroticized, visualized and commodified (p.33).

The book has two lines of enquiry. The first asks how Brazil can shed light on the significance of beauty as a domain of modern experience. The second involves using beauty as a lens to focus on some of the wider tensions in modernizing Brazil, including: deep market inequalities and a thriving consumer culture, a modern identity based on racial and cultural mixture and a newer assertion of identity politics, and a reputation for natural sensuality but high rates of interventionist medicine on the female body. The book comprises three parts (and the conclusion), each one dealing with a major domain of modern experience: medicine and psychology, race and nation, gender and sexuality.

Edmonds situates plastic surgery in relation to the economic, medical and psychic landscape of late capitalism, by focusing on issues such as the rise of mass media, the search for authentic national identity, and the importation of medical technologies. His analysis suggests how class identifications can be redefined and reshuffled in the culture of beauty. Drawing on the work of Biehl, J. (e.g. 2007), Edmonds demonstrates how new notions of ‘rights’ coexist with extreme market stratification, and how medical practices become part of the fetishization of the body and modern technology.

Edmonds then examines the place of beauty within the changing significance of colour in the post dictatorship period in Brazil, highlighting how a celebrity and media-focused consumer culture becomes a central domain of identification. He describes how a new black movement has called for a reconceptualization of race in Brazil as one of multiculturalism instead of the previous mestiçagem, or ‘racial democracy’, which diminished the ability to denounce racial inequality.

The use of the beauty culture as a lens to examine the issue of race in Brazil demonstrates the significance of the aesthetic dimension of modern subjectivities. As the colour hierarchy made appearance a central marker of social status, Edmonds shows how it is not surprising
that the current black movement should be framed in the same aesthetic idiom, i.e. as an affirmation of black beauty and of the rights of the black consumer (p.174).

The final section and conclusion bring together the central themes, analysing how gender and sexuality shape the medical practices, market dynamics and modes of self-governance that are discussed earlier in the book. Situating plastic surgery in relation to a larger political economy of female reproduction, Edmonds shows how it is becoming a normalized aspect of female health. Beauty cultures reflect larger changes in female sexuality and reproduction as they are defined within consumer culture, medicine, and psychology.

One of the clear advantages of Pretty Modern is the great depth of analysis that we are offered. Anecdotes and detailed descriptions provide the backdrop for theoretical discussions, fleshing out the arguments and providing the reader with a more rounded view of the issues. Edmonds conducted extensive fieldwork and so includes interviews with a wide range of informants: from famous pop stars and socialites, to maids who aspire to acquire plastic surgery, to favela residents who dream of fashion modelling, to single mothers who embrace plastic surgery as a means of erotic body sculpting.

Edmonds turns conventional arguments around plastic surgery in the social sciences on their head, as his aim is ‘to constitute beauty as a social domain that has its own internal logic that cannot be reduced to an operation of other forms of power’. Rather than view it only as a social construction he works from the assumption that physical attractiveness is an objective form of value, if not “possessed” by individuals, then observable within certain social relationships and moments’ (p.20).

Drawing on Agamben (1998), Edmonds argues that the proliferation of plastic surgery in Brazil reflects a biological framing of sexuality that breaks from the symbolic and ceremonial dimensions of erotic experience (p.240). This focus on the ‘biologization’ of sexuality and selves, leads Edmonds suggests that perhaps plastic surgery in Brazil thrives not off alienation from the body, ‘but rather an ethos even better suited to the expansion of the beauty industry: compulsory love of the body’ (p.237).

The emphasis on beauty as a domain of national or cultural identification, that also reflects and shapes ‘a particular kind of modern subject with diverse aspirations for self-transformation, social mobility, and sexual pleasure and power” (p.30), is illuminating and important. However in emphasising the argument Edmonds sometimes seems to simplify feminist theoretical approaches to beauty practices as being only about patriarchal domination.

Furthermore, Edmonds mentions Fukuyama and enhancement technologies, but he does not engage with the literature in depth. He only points out the tendency to isolate such technologies from their social and class contexts (p.73). Further engagement with the literature on plastic surgery in other cultures would also be helpful, e.g. Holliday, Cairnie (2007).

The slight disadvantage to such an ‘all-encompassing’ writing style is that the point may sometimes become a bit unclear in the thick description. Interestingly, however, Edmonds does discuss how the ‘delight in impurity and inauthentic hybridity’ that is part of ‘the ethos of Brazilian life’ have made their way into this presentation of his research (p.24). However this is not a major drawback, as overall, Pretty Modern is a very enjoyable, provocative and stimulating read.
REFERENCES:


Book Review

McNally, Richard J.

What is Mental Illness?


288pp

Reviewers: Caitlin Rivers and Justin Snyder

Saint Francis University
Loretto, PA, USA
jcr100@francis.edu

Sociologists interested in mental health and diagnosis should pay attention to this book. Among other things, it serves as an impressive preface to the upcoming DSM-V. Readers will not find a definitive answer to the question the title poses. To the question ‘What is mental illness?’ McNally answers, ‘It depends.’ Mental illness is many different things. It is a social construction, an outcome of genetics, an evolutionary artifact, and a kind of personal misery. McNally suggests that the most useful definition of mental disorder depends upon our aims. For example, classifying depression strictly by genetic determinates is a helpful ways of thinking about mental illness. Arguing that depression is a social construction is also helpful. However, neither may be useful for a therapist trying to aid a person in distress. McNally’s position may appear noncommittal, but it is a commitment to sobriety and nuance. Though he provides no new evidence or theory, his position is controversial and necessary challenge to the sociology of mental disorder. In the book, McNally, a Harvard psychiatrist and member of the DSM task-force on post-traumatic stress disorder (PTSD), explores the ‘boundary between mental disorder and mental distress’ through a review of the relevant literature. McNally’s review includes chapters on genetic and evolutionary conceptualizations of mental illness, and these chapters are a good critical introduction to those literatures. McNally, though sympathetic to sociological perspectives, also puts sociology through its paces in the chapters ‘Are We Pathologizing Everyday Life?’ and ‘Does Society Create (Some) Mental Disorders?’ In these two chapters, he discusses disorders such as depression, erectile dysfunction, bulimia, dissociative amnesia, multiple personality disorder, schizophrenia, and PTSD. Furthermore, in the chapter ‘Do Mental Disorders Differ by Kind or Degree?’ McNally offers a thoughtful discussion that can help sociologists clarify their definition of mental disorder. We found this chapter particularly valuable for its argument on the need to distinguish between operational concepts — which could mean also sociological usages — and diagnostic entities. As McNally argues, psychologists and psychiatrists often muddle the two. Sociologists should prevent this confusion from colouring our own work when we use, say, ‘depression’ or ‘schizophrenia’ in our regressions or in our arguments that mental disorders are socially constructed rather than naturally occurring entities.
McNally’s discussion of depression represents one way he matters for sociology. McNally discusses the upward trend in the diagnosis of depression by engaging the work of sociologist Allan Horwitz and his co-author Jerome Wakefield. Horwitz and Wakefield (2007) argue that normal sadness is increasingly diagnosed as depression, a pathology. McNally accepts this position but argues it resolves little by itself. He challenges the idea that there is a clear boundary between normal and abnormal distress. For example, the actual events or experiences that cause an individual’s depression may not be easily identified, which makes it difficult to determine if a person’s distress is an adaptive or maladaptive response. Furthermore, McNally is wary to deny treatment to distressed individuals who may be suffering severely but whose depression response is ‘expectable, reasonable, and warranted’ (p. 54). According to McNally, Horwitz and Wakefield’s arguments mean that a clinician should deny treatment to someone severely depressed who is ‘an impoverished, unemployed, single mother living in high crime neighborhood’ (p. 52). However, according to McNally, Horwitz and Wakefield’s argument instructs that treatment should be given to a severely depressed woman ‘with a loving, supportive husband, wonderful children, close friends, and a lucrative, satisfying career’ (p. 53). McNally admits that Horwitz and Wakefield’s aim ‘is to conduct a conceptual analysis, informed by data, to help us distinguish genuine mood disorder from nondisordered sadness’ (p. 54). McNally wonders, ‘[I]f their analysis provides only conceptual clarification, can it offer much guidance for clinical practitioners?’ (p. 54).

McNally’s concerns here raise an important issue for sociologists who study mental disorder. To what extent should our sociology be guided by clinical usefulness? How should an individual’s meaning and experience of distress figure into our analysis of the social and historical forces that guide diagnosis? McNally makes it imperative that we clarify the relationship between our aims and concepts.

McNally’s arguments are directly relevant to sociologists who study mental disorder and medical diagnosis, psychiatric or otherwise. The book is written for a wide academic audience and is suited for graduate and upper-level undergraduate courses. His ecumenism regarding the scientific conceptualization of mental disorder will certainly challenge. However, he also offers an ethical claim that answers the question ‘What is mental illness?’

McNally argues, ‘The boundary between mental distress and mental illness will never be neat and clean’ (p. 212). However, McNally does not believe that we are stuck with interminably incommensurable conceptualizations of depression, schizophrenia, posttraumatic stress disorder, and other psychological conditions. He believes that ‘[a] set of loosely correlated features tends to characterize mental disorders without any single feature being necessary and sufficient to make a condition a mental disorder’ (p. 212-3). Though, throughout the book, bubbling up for brief instances, especially in the final chapters, most forcefully in his last words, McNally argues for a more definitive judgment on the classification mental disorder. While it is right for definitions of mental disorder to be governed by particular aims, a single directive is the ultimate arbiter of our classificatory schemes. That directive is to reduce human suffering.
REFERENCES

My research and writing as a medical sociologist centres mainly on the social context of death and dying that covers issues such as end of life care, grief and bereavement, spirituality and the different models of health and social care organisation that provide support to dying and bereaved people. The recent purchase of the above 3 volumes very much reflects these broad interests and their contents promised some fascinating reading.

Death and dying, as often traumatic both for the dying person and those who are bereaved, can be understood as a form of loss that can disrupt the assumptive world of individuals and families. However, loss in life that is non-death loss can be equally threatening to our assumptive world and is experienced in a myriad of ways. The Harris volume takes a multi-dimensional perspective on loss and was the starting point for my reading. Drawing on a wide range of contributions, this volume discusses loss in a variety of forms and contexts. Experience of domestic violence, adoption, migration, unemployment, ‘coming out’ as a gay person and ambiguous and nonfinite losses, such as those associated with addiction and divorce, are discussed through a sociological lens and life course perspective.

Material is usefully organised into four themed sections that focus on loss of safety and relational loss, loss of meaning, loss of view of self as worthy or valuable and the last section that has coping with losses in life as its overarching theme. The organisation of the volume in this way enables the reader to make theoretical and empirical connections across different types of loss experience whilst also being able to consider the impact of very specific forms.
of loss. The volume’s diversity is a particular strength and is recommended reading for anyone working in ‘helping’ professional care roles.

Diversity as social difference in terms of culture, ethnicity, family structures and social disadvantage is the subject of Oliviere et al’s volume that discusses the impact of social structures on the experience of death and dying. This second edition of an earlier volume published in 2004 analyses the wide range of social factors and differences that can affect access to services, assessment and individual and family experience as death approaches. Chapters on palliative care for disadvantaged groups such as prisoners and substance misusers highlight the practical challenges faced by health care professionals and policy makers in making the rhetoric of high quality end of life care for all a reality. The end of life care needs of other vulnerable groups such as homeless people and those with disabilities and mental health problems are the focus of individual chapters that foreground the ways in which stereotyping can deny access to appropriate services resulting in the further marginalisation of these groups as death approaches. The overarching message of this multi-authored volume is that although there has been significant improvement in access to palliative care, some groups in our society continue to experience ‘disadvantaged dying’ and, with increasing financial pressure on health services of all kinds, it may be increasingly difficult to provide sensitive and ‘tailored’ care for these groups of patients.

An individual and ‘tailored’ approach to providing spiritual support to dying people is the topic of Steve Nolan’s book that draws on his experience of working as a chaplain in an English hospice. I was particularly interested to read this book as, in the past, I have taken a critical stance toward the ‘professional’ delivery of spiritual care for those who are facing the end of their life. The emphasis on ‘being present’ with a dying person in the context of their values and belief system is strongly drawn out in this book, with Nolan arguing for a re-theorisation of spiritual care as presence. The argument is powerfully made through the use of a number of case studies that illustrate how being with a dying person, giving them whole attention can be transformative to engender hope both in the present and for others. The conceptual clarity developed by Nolan of hope as multi-dimensional to incorporate understanding of hope along a continuum of hopefulness to hopelessness I found particularly useful.

The other major contribution of this book is its discussion of the importance on the part of spiritual care workers, in their support of dying people, to acknowledge their own death anxiety. It is this, Nolan contends, that is at the root of true empathy with the dying other. Care of the human spirit of another is not just the work of spiritual/religious specialists and, although Nolan recognises this, he nevertheless maintains the view that the training within chaplaincy particularly equips chaplains, such as himself, for this demanding and sensitive work. I very much enjoyed this book because of its use of case study experience, but also because of its open and exploratory discussion of a number of complex theoretical ideas.

These three books provide rich food for thought about the experience of death and dying and other kinds of loss in contemporary society and offer the reader compelling accounts of the experience of loss together with relevant explanatory frameworks.