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How U.S. 'cultural defaults' challenge American public health and what public health officers can do about it

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ABSTRACT

As practitioners and scientists reflect on what can be learned from COVID, we argue that cultural defaults—commonsense, rational, and taken-for-granted ways of thinking, feeling, and acting —played an important role in how countries responded to the pandemic, and help explain why the United States suffered 4-6 times more deaths per 100,000 people compared to the East Asian countries of Japan, Taiwan, and South Korea. Drawing on a recent review and theoretical integration, we describe six pairs of contrasting cultural defaults that were common in how the U.S. and some East Asian nations responded to the pandemic: (1) optimism-uniqueness vs. realism-similarity, (2) single vs. multiple causes, (3) expression of high vs. low arousal emotions, (4) influence-control vs. wait-adjust, (5) personal choice-self-regulation vs. social choice-social regulation, and (6) promotion vs. prevention. These historically-derived defaults are often outside of individual awareness, but are reflected in and reinforced by institutional practices and policies, the media, and everyday interactions. They are infused with cultural values, understood as the "right way" to be or behave, and are adaptive in their respective contexts. Importantly, both constellations of cultural defaults are viable depending on the problem to be solved. We then provide six specific ways in which public health officers might productively consider these and other cultural defaults when preparing for the next crisis and planning how to effectively motivate people to protect their own and others' health. Our hope is to facilitate efforts to include a focus on culture within the scope of the social determinants of health and to encourage more partnerships between behavioral scientists and public health practitioners. Recognizing the cultural defaults of the various "publics" they seek to protect is critical as U.S. public health officers aim to promote health for all, a significant and complex challenge in the increasingly individualistic U.S.

1. Introduction

As Americans grapple with how to respond to a measles outbreak, receive weekly word of new virulent diseases that could lead to the next pandemic, and mark the fifth anniversary of the beginning of COVID, what can social scientists and practitioners say we learned from COVID, which killed 7 million people, and disrupted and altered the landscape of work and social life worldwide? Why did so many people in the United States resist public health measures? Why were some U.S. public health officers physically threatened and verbally abused while trying to protect their communities? How can we use our COVID experiences to minimize the human and economic costs of the next pandemic and other future public health crises?

One inescapable fact is that the U.S. suffered 4-6 times more deaths per 100 thousand people than did the East Asian countries of Japan, Taiwan, and South Korea (Johns Hopkins Coronavirus Resource Center, 2023). Especially early on, the U.S. had difficulty containing the spread of COVID compared to these countries. Why? **We contend that one of the profound lessons of the pandemic is that different constellations of cultural defaults—commonsense, rational, and taken-for-granted ways of thinking, feeling, and acting —played an important role in how countries responded to the pandemic**. In a recently published paper Markus et al. (2024), we introduce the concept of *cultural defaults* with the goal of unpacking *how* the broad and well-known cultural imperatives of individualism and collectivism translated into specific culturally variable habits of thinking, feeling,

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and acting that closely tracked the differences in how nations responded to and controlled the pandemic.

Why is a greater awareness of these cultural defaults necessary for those charged with understanding and protecting public health? In novel, complex, and frightening circumstances like those of the pandemic and other easily imagined crises, **the default ways to think, feel, and act often guide public understanding and behavior even though they may not be the only viable ways to respond**. Recognition of these cultural defaults could have forecast many of the striking differences in responses and outcomes between the U.S. and these East Asian countries. More importantly, insight into the cultural defaults prevalent in the contexts of their constituents could have helped decision makers and policymakers formulate recommendations, design programs, and craft narratives for controlling the pandemic in their respective communities more effectively. In public health, cultural defaults have yet to be investigated in depth despite acknowledgement that culture matters (Chandra et al., 2017; Dahlgren & Whitehead, 1991; Kawachi, 2024). Understanding and addressing these cultural defaults can decrease the likelihood of resistance, backlash, and division among the general public to recommendations and policies aimed at saving their lives.

In Markus et al. (2024), we synthesize decades of empirical research in cultural psychology that reveal some of the different cultural defaults evident in the U.S. and parts of East Asia; show how these defaults were mirrored in the statements of high level public officials and their constituents' responses during the pandemic; and propose ways of considering cultural defaults in future crisis management. Our analysis begins with this particular comparison because it is the one that has generated the most substantial empirical base so far. Moreover, the East Asian nations we analyze, while unique in many respects, are alike in their foundation in collectivistic ideas and practices, which contrast with those of the individualistic U.S. Here we briefly summarize this detailed paper (see Markus et al., 2024 for a more complete discussion of defaults, including additional references and full quotations).

2. Cultural defaults in the U.S. and East Asia during the pandemic

Confronting the same set of frightening pandemic questions—-Will it happen to me? Why is this happening? How should I feel about this crisis? What should we do?—people and organizations in the U.S. and in some East Asian nations relied on different constellations of cultural defaults and responded to the pandemic in different, sometimes opposite ways. Although these cultural defaults are neither inherently good nor bad, these different ways of responding were more or less effective during different stages of the pandemic and together likely contributed to the national disparities in COVID deaths.

In American cultural contexts, many people were initially *optimistic* that COVID would not be much of a problem, and if it became so, they could handle it. They looked for a *single cause* of the spreading virus, expressed anger about the pandemic but enthusiasm and other *high arousal* emotional states that they could overcome it, *took action, resisted being told what to do*, even, and perhaps especially, if authorities mandated it, and when COVID started to decline, *focused on living a better future life with more positive outcomes*.

In contrast, in some East Asian cultural contexts, the common response was more *realistic* and *assumed that the crisis would affect them.* People and organizations identified *multiple causes* that were likely underlying the origin and spread of COVID; *encouraged calm and other low arousal* emotional states*, waited to see what unfolded before acting, adjusted their behavior to fit with others' actions, and* as COVID declined, *worried about avoiding risk and preventing future negative outcomes.*

These strikingly variable responses to the pandemic are not fixed human tendencies or stereotypes. Instead they are psychological tendencies that are built into their respective national cultures–-into pervasive ideas and values, the unspoken design and workings of institutions, and the practices and norms of social networks and daily interactions. These defaults have evolved over time and reflect entrenched values and moral commitments about the right and best ways to be and live. Like water to fish, humans are often unaware of the many aspects of the cultures that support and animate them (see Table 1 for definitions of some cultural defaults common in the U.S. and East Asia that were relevant to the pandemic).

Table 1
Cultural defaults during the pandemic.

Pandemic Questions	Common Answers in the U.S.	Common Answers in East Asia
Will it happen to me/us?	**Optimism-uniqueness:** Viewing the self (and the nation) as (a) likely to have more positive and less negative future outcomes and (b) special and unique.	**Realism-similarity:** Viewing the self (and the nation) as (a) likely to experience a balance of both positive and negative future outcomes and (b) similar to others.
Why is this happening?	**Single cause**: Attributing the crisis to one cause, usually an individual or one group.	**Multiple causes:** Attributing the crisis to multiple causes, including individuals, groups, situations and themselves.
How should I/we feel?	**Higher arousal**: Encouraging higher arousal (e.g., anger, enthusiasm) to assert and motivate self and others.	**Lower arousal:** Encouraging lower arousal (e.g., calmness, quiet) to attend to others and the situation.
What should I/we do?	**Influence and control**: Exerting influence; acting quickly; taking control over the situation through individual action.	**Wait and adjust**: Refraining from quick decisions; referencing others and developing consensus before taking action.
How should I/we respond to government guidelines?	**Personal choice and self-regulation**: "Freely" choosing to do what I want; motivated by personal preferences; resistant to regulation by others.	**Social choice and social regulation:** Choosing to do what others want; motivated by concern for others and social norms; responsive to regulation by others.
How should I/we re-open and live now?	**Promotion:** Reframing the crisis as an opportunity for future positive outcomes and growth rather than a threat.	**Prevention:** Focusing on mitigating the negative outcomes and threat of the crisis and preventing future crises.

Adapted from Markus et al. (2024)

One feature underlying and connecting the U.S. cultural defaults discussed here is a deeply-rooted cultural priority accorded to the thoughts, feelings, and actions of the *individual* over those of the group, and to the *independent agency* that is encouraged and fostered in these individualistic contexts (e.g., Hofstede, 1980; Markus & Kitayama, 2010). Underlying the East Asian cultural defaults discussed here is a cultural priority given to the thoughts, feelings and actions of a significant *collective or group* of which an individual is part, and to the *interdependent agency* that these collectivistic contexts foster (e.g., Hamamura, Bettache, & Xu, 2018; Hofstede, 1980; Markus and Kitayama, 2010). As we detail in our paper, both sets of cultural defaults are useful guides for behavior in their respective contexts, but depending on the crisis and how they are applied can be more or less effective. **The message of this commentary is that the public health goal of promoting health for all is a challenge in the increasingly individualistic U.S., and that recognizing these underlying cultural defaults can help.**

Importantly, these constellations of cultural defaults are deeply intertwined and implicated in the many other important drivers of national differences in per capita mortality during COVID (e.g., the quality, financing, and integration of public health systems; the amount of distrust between people and government; levels of economic and racial inequality; strength of social safety nets; extent of political polarization).

Below we briefly characterize a set of defaults well-supported by previous empirical literature that we observed in the public response to the pandemic.

2.1. The optimism-uniqueness default vs the realism-similarity default

As COVID emerged and people wondered, “Will it happen here?,” the *optimism-uniqueness default* of the U.S. and t*he realism-similarity default* of parts of East Asia were on full display. These different defaults are supported by decades of survey and experimental research showing that U.S. Americans are more likely to predict that positive things will happen to them, are less likely to predict that negative things will happen to them (e.g., Fischer & Chalmers, 2008); and are more likely to see themselves as unique and special compared to East Asians (e.g., Zell et al., 2020).

Consistent with these defaults, Larry Kudlow, former director the National Economic council claimed early in the pandemic that “We have contained this,” (Imbert, 2020) and President Trump offered “It’s going to disappear. One day, it’s like a miracle, it will disappear,” (Vasquez & Kelly, 2020). In contrast, former Prime Minister Abe of Japan said, “fighting an enemy that is hard to see and to understand is not easy” and “This is most certainly not someone else’s problem,” (Abe, 2020). Perhaps believing it wouldn’t happen to them, the U.S. was inconsistent in the early detection and action necessary to prevent the spread of the disease (Leonhardt, 2020). In Japan, Taiwan and South Korea, however, the realism-similarity default led people to worry that even without symptoms, they might already have the virus and could spread it. Concern over being a vector of transmission worked to foster nationwide adherence to a system of early detection and action, resulting in proportionally fewer deaths in East Asia than the United States, especially early on.

2.2. The single cause default vs the multiple cause default

As COVID spread, people sought to understand its cause. Studies repeatedly show that in explaining the events of their lives, people in the U.S. tend to focus on the stable internal attributes of the person or the group directly involved in the event—a *single* cause—, whereas East Asians are more likely to consider situational factors as well as their own role in an event, or *multiple* causes (e.g., Choi et al., 1999; Choi et al., 2003).

The *single cause default* was pervasive in the statements of many U.S. public officials and in the mainstream press who referred to COVID as the “Wuhan Flu” or “the China virus.” And for some, this single cause attribution inspired retribution: Asian Americans became a target of discrimination and hate (Lo et al., 2022). While national leaders in Japan recognized that the virus originated in China, they were also aware of other causes (e.g., globalization, economic dependence on China) and cautioned citizens to “know the multiple backgrounds of a particular theory in order not to be drawn into it” (Kubota, 2020). In the U.S., by contrast, the single and sharp focus on whom to blame for the virus may have slowed the search for understanding the causes and the consequences of its spread. In contrast, the *multiple cause default* common in many East Asian countries encouraged a concern with the source of the virus, but *also* with the sources and consequences of its rapid transmission. This more holistic focus allowed many East Asian countries to develop an early understanding that social distancing, masking, and isolation would curb the spread of COVID, again resulting in far fewer deaths early on.

2.3. The high arousal default vs the low arousal default

Once the threat could no longer be denied, the next question was how people should react or feel. In general, European Americans report wanting to feel excited, enthusiastic, and other *high arousal* positive states more than Chinese, Taiwanese, Japanese, and South Koreans (e.g., Tsai et al., 2006; Tsai et al., 2025). In contrast, many East Asian norms, practices, and rituals encourage the experience and expression of calm and other *low arousal* positive states (Clobert et al., 2020; Tsai et al., 2006). In response to a negative event, however, the *high arousal* default leads to greater expression of anger and hostility among U.S. Americans, whereas the low arousal default leads to reframing of the negative event and focus on doing better the next time (Uchida & Kitayama, 2009).

President Trump described the virus as “the invisible enemy” while promising “total victory” over it, eliciting both anger and enthusiasm (BBC, 2020). In contrast, former President of Taiwan, Tsai Ingwen, asked citizens to “remain calm … stay tuned for outbreak information provided by the government, and strengthen their personal hygiene routines” (Office of the President, Republic of China (Taiwan), 2020). Although some Americans reported *wanting* to feel more calm during the pandemic, their high arousal default was frequently on display. There were vocal protests against lockdowns, social distancing measures, and mask requirements. Some Americans attacked flight attendants, nurses, salespersons, and public health officers to resist COVID guidelines. While there were also critics of government responses to the pandemic in many East Asian countries, there were essentially no overt public expressions of anger, hostility, and frustration like those seen in the U.S.

2.4. The influence and control default vs the wait and adjust default

Once people and organizations across the world recognized the significant threat of the pandemic and grappled with the question of “what to do about it?,” the American default to try to do something exceptional and quickly—the *influence and control* default—kicked in. In contrast, in East Asia, the default was to first implement well-practiced and standard procedures (e.g., masking, social distancing) and then to *wait and adjust* to the situation as it unfolded. Research demonstrates that whereas U.S. cultural practices emphasize having influence and control, Japanese cultural practices emphasize adjusting to others, and these different emphases matter for well-being in the cultures (e.g., Morling et al., 2002).

The influence and control default led to the rapid production of vaccines in the U.S. As described by President Trump, “It’s called Operation Warp Speed. That means big and it means fast … Incredible” (U.S. Embassy Tbilisi, 2020). In contrast, Yasutoshi Nishimura, the minister leading Japan’s COVID response said, “We are taking a cautious approach and considering all factors before deciding on the implementation of stronger measures” (Nishimura, 2020). The Japanese government explained their considerable delay in vaccination as “necessary to build confidence in the vaccine,” (Yamaguchi, 2021) demonstrating the *wait and adjust* default, in part perhaps because they had already effectively contained the deadly virus.

2.5. The personal choice and self-regulation default vs the social choice and social-regulation default

Government orders to stay home, socially distance, and mask clashed with the powerful *personal choice and self-regulation* default of the U.S., but were consistent with the *social choice and social regulation* default of East Asia. A strong empirical literature demonstrates that personal choice is more central to identity, life satisfaction, and well-being in the U.S. than in East Asia (e.g., Madan et al., 2020), in part because East Asian contexts are replete with systems and social infrastructure that prioritize state centralization, the common good, interdependence, and responsibility (e.g, Uchida & Rappleye, 2024).

As President Trump declared about wearing a mask, “You can do it. You don’t have to do it. I am choosing not to do it. It may be good. It is only a recommendation, voluntary” (Mills, 2020). In many places in the U.S., resistance to government orders became a hallmark of the pandemic and took the form of “no one, especially the government, can tell me what to do.” The contrasting high level of compliance in East Asia reflects the default of social choice and social regulation. As described by

Jerome Kim, director general of the International Vaccine Institute in South Korea, people were not without a choice in their response but they largely chose to cooperate: “I think there are a number of choices people here have made to have freedom” (Gallo, 2021). In many parts of East Asia, the actions of the public took the form of “we will cooperate and follow the guidelines because others are doing it, they expect me to do it, and we will all benefit.” For example, even though the U.S. had access to vaccines sooner, by the end of 2021, the percentage of fully-vaccinated individuals was greater in Japan than in the U.S.

2.6. The promotion default vs the prevention default

By 2022, two years into the pandemic, people began to ask “how should we live now?” Many experimental studies find that Americans are more oriented to maximizing positive outcomes and seeking gains—-*the promotion default,* whereas East Asians tend to minimize negative outcomes and avoid losses—*the prevention default* (e.g., Salvador et al., 2022).

The promotion default was evident in former President Biden’s assertion in September 2022 that COVID was over, even though many public health officials declared that it was not (Archie, 2022). In contrast, parts of East Asia still had COVID procedures in place, reflecting a prevention default. As Shih-Chung Chen, the former Minister of Health and Welfare for Taiwan, stated, citizens could “lead normal lives while active epidemic prevention measures remain in place and the country is steadily opening up” (Chen, 2022, para. 8). U.S. Americans were ready to get on with their lives, and those with sufficient resources imagined better lives than the ones they lived pre-COVID. In contrast, many East Asians were less focused on leading their best lives and were more focused on maintaining safety and preventing spread. There was a widespread understanding in East Asia that COVID was still present and that people must adjust their lives to prevent it.

3. Cultural defaults for the future

How can understanding the cultural defaults listed above (and others from other parts of the world) be useful to decision-makers in public health? Protecting and improving the health of people and their communities requires strengthening the “essential” capabilities of public health including emergency preparedness and response; assessment and surveillance; communication; policy development and support; and community partnership and support (DeSalvo et al., 2021), but it also requires an understanding of the many cultural contexts in which people participate, so that public health officers can respond to the specific needs of a given population. Multiple commentators have written about the deep challenges facing public health agencies well before, during, and now after the COVID pandemic that would ideally be addressed in time for the next pandemic. These include lack of sufficient funding, inconsistent support among politicians, and the fragmentation of the American health system. Few have entertained the possibility that these challenges at their core reflect a deep suspicion of the mandates of public health because they conflict with U.S. American defaults related to individualism and independence (Hook & Markus, 2020). In the next section, we outline some ways in which public health officers and their teams in the U.S. might consider the role of cultural defaults in their responses to the next public health crisis, whether it be bird flu, Ebola, polio, measles, or the next variant of COVID.

3.1. Lesson 1: Recognize the role of cultural defaults in commonsense responses to the health crisis

Seeing cultural defaults at work in one’s own response, planning, and decision making is not easy, but it is a necessary first step in leveraging cultural defaults to promote public health. In a commentary written after reading our paper, Dr. Sara Cody, a public health officer and director, realized how her own actions and those of her emergency response team reflected the constellation of defaults common in the U.S. (Cody, 2024). She and her team knew they had to act quickly and decisively to contain the virus (*influence and control default*), even when most people were optimistic that COVID would not enter the U.S. With enthusiasm and energy (*high arousal default*), they set to work, believing that “if we mobilized enough resources and worked hard enough to find and track each case and contact, we would be able to contain the virus” (*optimism-uniqueness default*). Yet when it became clear that there was a nationwide shortage of personal protective equipment, Cody’s office mandated that all entities and individuals in the county disclose their inventories so they could be deployed throughout the country. This is when their troubles began. Mandating that people share their resources clashed with the powerful U.S. default of personal choice and self-regulation. Cody (2024) acknowledges, “The orders that I issued were essentially mandating collectivism—that people did not gather, did not form crowds, and wore masks to protect each other,” which was different from the individualistic defaults of many people in her county. In other words, public health officials might well benefit from a recognition of the defaults in their own responses, but even more importantly in the responses of the people in the communities they serve.

Recognizing that the U.S. was not prepared for COVID in part because of its *optimism-uniqueness* default, we can ask whether the same default is shaping our view of current viruses. For example, is it really the case that bird flu is only a concern for people who consume raw milk products and are in close proximity with animals, or are we being too optimistic that this is the case? This leads to Lesson 2.

3.2. Lesson 2: Consider alternate cultural defaults to expand the scope of possibility

For public health officers, a systematic comparison of their own (and their constituents’) immediate and commonsense responses to the well-known and useful defaults of decision-makers (and their constituents) in other contexts is the next step. Of course, the cultural defaults of one’s own context will not be easily swapped out for another set. For individual public health officials in the U.S. charged with the responsibility of protecting the well-being of those in their counties, deciding to “wait and see” would be a challenge. Yet one’s own set of defaults might be broadened, balanced, or nuanced by deliberately reconstruing a situation or crisis through the established defaults of decision-makers in other contexts. Taking a page from an East Asian motivational playbook, is it possible to normalize the understanding that easily transmissible viruses are now part of life, and to more calmly and consistently suggest through multiple channels that it makes sense to take certain precautions (e.g., wear a mask), first to protect yourself, and next, to protect others around you? Tamping down the high arousal default through early, engaging but relatively calm messaging has the potential to simultaneously slow the application of the single cause default and the search for a single culprit to blame. This may in turn accelerate understanding of the virus and how to stem its spread, as well as guard against high arousal displays of anger over a restriction of freedom and individual rights. Different crises (and even different stages of a crisis) may require the wisdom of different defaults, and a mix of responses may be the most effective.

3.3. Lesson 3: Frame behavioral recommendations in terms of cultural defaults

Research across multiple domains demonstrates the importance of matching a message with an audience’s general motivational orientation. One clear lesson is to frame public health recommendations or mandates in a way that builds on prevalent cultural defaults. London Breed, the former mayor of San Francisco, urged people to wear a mask so they could be “free” to travel. This recommendation was a good fit with the personal choice and self-regulation default. Similar framings were “Choose to be healthy,” “Protect yourself, stay home,” “Take control, your health is in your hands,” and “You have the power to influence others, wear a mask." Notably, however, the messages that most effectively leveraged the influence and control and personal choice defaults may have been those that *directly countered* the advice of public health officials and rallied people against masks and vaccines (e.g., "My body, my choice," "Let me call my own shots").

Uptake of a behavioral recommendation in the U.S. is most likely when it is easy, fun, rewarding, and social (e.g.,Thaler & Sunstein, 2008). To this list we add that recommendations should be consistent with dominant cultural defaults whenever possible. If a recommended behavior counters a default, it should be immediately followed by a recommendation that is consistent with the default. As one example, masking can hinder people's abilities to see others' facial expressions, which, for many in the U.S., meant removing their ability to communicate effectively. To counter this, Stanford Health Care workers pinned pictures of themselves without their masks on their lab coats so that they could express themselves and connect with patients while wearing a mask (Sashin, 2020).

3.4. Lesson 4: Address cultural defaults at multiple interacting levels of culture (individual, interactional, institutional, and ideas)

Recommendations and guidelines do not exist in a vacuum. Cultural defaults are reflected in individual attitudes and beliefs, but they persist because they are also inscribed in institutional policies and practices. Effective change in behavior thus requires intervention at multiple levels (Hamedani et al., 2024). For example, the widespread idea that one's health is a private matter and that public health mandates restrict personal choice are reflected in the very structure of the U.S. health system. Personal health organizations and public health systems in the U.S. are distinct and separate entities. In Japan, South Korea, and Taiwan, public health is coordinated by their national governments. In contrast, public health in the U.S. is the responsibility of a pluralistic, decentralized assortment of more than 3000 state and local public health offices that have incompatible data systems and few means to communicate with each other. Although this system provides room for individual choice and for tailoring policies to the local community (DeSalvo et al., 2021), it also means that state and local jurisdictions are left on their own to develop public health guidance. As a result, during the pandemic, many policies and actions that required individuals and private health organizations to cooperate with public health systems for the "the good of all" or for "community benefit" were very difficult to enforce. The lesson here is that one can endorse a "we are in this together" sentiment, but if the institutional policies and practices that afford cooperation and coordination do not exist, such appeals are unlikely to take hold for any extended period of time. A more effective response to future pandemics will stem from encouraging connection and collaboration among autonomous state public health systems, but also from establishing uniform standards for data collection, and requiring that all states report data on the health status of their populations. Inscribing this level of structural interdependence into a system designed for independence will require creative applications of Lesson 3 at multiple levels of culture.

3.5. Lesson 5: Prepare for resistance to counter-cultural default recommendations

Sheltering in place, masking, social distancing, contact tracing, testing, and vaccinating were the only ways of preventing the social transmission of this deadly disease. While Americans in certain parts of the U.S. complied with these unusual regulations for a time, people across the country became tired, angry, and frustrated with them, in large part because they ran against defaults of personal choice and self-regulation. One of the most alarming consequences of the pandemic was violence waged against public health officers and healthcare workers "due to the political frustration of citizens nationally, who feel that their personal liberties have been encroached" (Burke et al., 2023, p. 2). Survey data collected in 2020 reported that between 9 and 12 % of public health officials received personal or family threats, including receiving emails questioning their authority, having their office doors knocked down, and having protestors show up at their private homes (Ward et al., 2022). To prepare for resistance, public health officers and/or government leaders might enlist the help of a wide variety of trusted local messengers who can communicate the rationale underlying their recommendations, provide feedback on the effectiveness of these measures, prepare citizens for the anger and frustration they may feel when they comply over long periods of time, and endorse alternative actions.

3.6. Lesson 6: Prepare for revisionist thinking

For many, COVID is already a distant memory. Cultural defaults shape what these distant memories are, and at least in the U.S., are likely to interfere with efforts to prepare for the next crisis. For example, the Spanish flu of 1918 killed millions of people worldwide. In the U.S., 675,000 people died, for many of the same reasons that people died during COVID: inconsistent guidance from top officials, lack of coordination among local health officials, substantial resistance to measures to curb the spread of the disease, and an anti-mask movement (Bristow, 2012). What prevented us from learning from our mistakes? Bristow argues that American exceptionalism, or the idea that Americans are special and unique, can drive a cultural forgetting and revision of the past as more positive than it actually was. Epidemiologist Katelyn Jetelina observes a similar process occurring for COVID: "I think there's an attempt to revise 2020 really under the comfort of 2023 vaccines and treatment and immunity" (Klein, 2023). This process of revisionism makes it particularly difficult to look back at the past, evaluate the outcomes of previous decisions, and consider alternate paths in the future. As a guard against revisionism, policy makers and researchers might consider fully documenting their actions and the resistance to them as they unfold, with the hope that this record may contain a fuller picture of the past than culturally shaped memory allows.

4. Conclusion

After five years of COVID, what have we learned? That **cultural defaults matter.** When describing his disbelief that so many Americans refused to get vaccinated, Francis Collins, former director of the National Institutes of Health said, "There are things about human behavior that I don't think we invested enough into understanding" (Simmons-Duffin, 2021). We agree. This includes understanding what cultural defaults are, how they work together to influence behavior, how they can sometimes limit our response to urgent crises, and how they can be effectively leveraged to get people to do things they aren't used to doing, but need to do to protect their own and others' health. Although we have focused on some U.S. and East Asian defaults, all nations have specific cultural defaults that require identification and attention as policy makers try to explain, motivate, predict, and influence behavior.

Public health is a field rooted in ensuring conditions that allow the maximum number of people in a population to be healthy. Yet in the U.S., the meaning of "public" and the "collective good" is elusive. In a highly individualistic society, fulfilling the public health charge means swimming upstream as practitioners try to persuade their many American "publics" that health is not just a personal responsibility, and that effectively protecting the "me" requires protecting the "we." In a multicultural, multiracial, politically-divided society with an increasingly decentralized government, the role of public health officers will be even more important, as will their need to be attuned to the cultural defaults of their local communities. Our hope is that partnerships between public health practitioners and behavioral scientists can facilitate efforts to include culture within the scope of the social determinants of health.

CRediT authorship contribution statement

Hazel Rose Markus: Conceptualization, Investigation, Writing – original draft, Writing – review & editing. **Jeanne L. Tsai:** Conceptualization, Investigation, Writing – original draft, Writing – review & editing. **Yukiko Uchida:** Conceptualization, Investigation, Writing – original draft. **Amrita Maitreyi:** Writing – review & editing. **Angela Yang:** Investigation, Writing – original draft.

Authors' note

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Ethical Statement

This material is the authors' own original work, which is based on a recently published article by the same team (Markus, Tsai, Uchida, Yang, and Maitreyi, 2024). The paper reflects the authors' own research and analysis and properly credits the meaningful contributions of the authors. All sources are properly disclosed.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

No data were used for the research described in the article.

References

Abe, S. (2020). *[COVID-19] Press conference by the prime minister (opening statement)*. Prime Minister of Japan and His Cabinet https://japan.kantei.go.jp/98_abe/statement/202002/_00002.html.

Archie, A. (2022). *Joe Biden says the COVID-19 pandemic is over. This is what the data tells us*. NPR. https://www.npr.org/2022/09/19/1123767437/joe-bidencovid-19-pandemic-over.

BBC. (2020). Coronavirus: Trump puts US on war footing to combat outbreak. https://www.bbc.com/news/world-us-canada-51955450.

Bristow, N. (2012). *American pandemic: The lost worlds of the 1918 influenza epidemic*. Oxford University Press.

Burke, R. V., Distler, A. S., McCall, T. C., Hunter, E., Dhapodkar, S., Chiari-Keith, L., & Alford, A. A. (2023). A qualitative analysis of public health officials' experience in California during COVID-19: Priorities and recommendations. *Frontiers in Public Health, 11*, Article 1175661. https://doi.org/10.3389/fpubh.2023.1175661

Chandra, A., Acosta, J., Carman, K. G., Dubowitz, T., Leviton, L., Martin, L. T., Miller, C., Nelson, C., Orleans, T., Tait, M., Trujillo, M., Towe, V., Yeung, D., & Plough, A. L. (2017). Building a national culture of health. *Rand Health Quarterly, 6*(2), 3.

Chen, S. C. (2022). Taiwan's COVID-19 containment strategy utilizing innovative technology and universal health coverage. *Taipei Economic and Cultural Office in Miami*. https://www.roc-taiwan.org/usmia_en/post/7476.html.

Choi, I., Dalal, R., Kim-Prieto, C., & Park, H. (2003). Culture and judgment of causal relevance. *Journal of Personality and Social Psychology, 84*(1), 46–59. https://doi.org/10.1037/0022-3514.84.1.46

Choi, I., Nisbett, R. E., & Norenzayan, A. (1999). Causal attribution across cultures: Variation and universality. *Psychological Bulletin, 125*(1), 47–63. https://doi.org/10.1037/0033-2909.125.1.47

Clobert, M., Sims, T. L., Yoo, J., Miyamoto, Y., Markus, H. R., Karasawa, M., & Levine, C. S. (2020). Feeling excited or taking a bath: Do distinct pathways underlie the positive affect–health link in the U.S. and Japan? *Emotion, 20*(2), 164–178. https://doi.org/10.1037/emo0000531

Cody, S. H. (2024). COVID and cultural defaults: A public health officer's personal perspective. *Psychological Science in the Public Interest, 25*(2), 31–35. https://doi.org/10.1177/15291006241280948

Dahlgren, G., & Whitehead, M. (1991). Policies and strategies to promote social equity in health. *Background document to WHO - strategy paper for Europe (working paper No. 2007:14)*. Institute for Future Studies. https://ideas.repec.org/p/hhs/ifswps/2007_014.html.

DeSalvo, K., Hughes, B., Bassett, M., Benjamin, G., Fraser, M., Galea, S., & Gracia, J. N. (2021). Public health COVID-19 impact assessment: Lessons learned and compelling needs. *NAM Perspectives*. https://doi.org/10.31478/202104c

Fischer, R., & Chalmers, A. (2008). Is optimism universal? A meta-analytical investigation of optimism levels across 22 nations. *Personality and Individual Differences, 45*(5), 378–382. https://doi.org/10.1016/j.paid.2008.05.008

Hamamura, T., Bettache, K., & Xu, Y. (2018). Individualism and collectivism. In V. Zeigler-Hill & T. Shackelford (Eds.), *The SAGE handbook of personality and individual differences: Volume II: Origins of personality and individual differences* (pp. 365-382). Sage. https://doi.org/10.4135/9781526451200.n20.

Gallo, W. (2021). South Korea showed how to contain COVID, now it will try to live with it. *Voice of America*. https://voanews.com/a/south-korea-showed-how-to-contain-covid-now-it-will-try-to-live-with-it/6301110.html.

Hamedani, M. G., Markus, H. R., Hetey, R. C., & Eberhardt, J. L. (2024). We built this culture (so we can change it): Seven principles for intentional culture change. *American Psychologist, 79*(3), 384–402. https://doi.org/10.1037/amp0001209

Hofstede, G. (1980). *Culture's consequences: International differences in work-related values*. Sage.

Hook, C. J., & Markus, H. R. (2020). Health in the United States: Are appeals to choice and personal responsibility making Americans sick? *Perspectives on Psychological Science, 15*(3), 643–664. https://doi.org/10.1177/1745691619896252

Imbert, F. (2020). Larry Kudlow says US has contained the coronavirus and the economy is holding up nicely. *CNBC*. https://www.cnbc.com/2020/02/25/larrykudlow-says-us-has-contained-the-coronavirus-and-theeconomy-is-holding-up-nicely.html.

Johns Hopkins Coronavirus Resource Center. (2023). *Mortality analyses*. Johns Hopkins University & Medicine. https://coronavirus.jhu.edu/data/mortality.

Kawachi, I. (2024). Culture as a social determinant of health. *Psychological Science in the Public Interest, 25*(2), 36–40. https://doi.org/10.1177/15291006241279145

Klein, E. (2023). It's time to talk about 'pandemic revisionism:' the epidemiologist Katelyn Jetelina takes stock of school closures, mask mandates and the pandemic response [Audio podcast episode]. In The Ezra Klein Show. The New York Times (Host) https://www.nytimes.com/2023/08/29/opinion/ezra-klein-podcast-katelyn-jetelina.html.

Kubota, M. (2020). 「新型コロナは中国の人工ウ イルス」と信じる人が後を絶たない理由 [Why people continue to believe that "the novel coronavirus is a manmade virus from China]. *Diamond Online*. https://diamond.jp/articles/-/235514?page=5.

Leonhardt, D. (2020). The unique U.S. failure to control the virus. *The New York Times*. https://www.nytimes.com/2020/08/06/us/coronavirus-us.html.

Lo, R. F., Padgett, J. K., Cila, J., Sasaki, J. Y., & Lalonde, R. N. (2022). The reemergence of Yellow Peril: Beliefs in the Asian health hazard stereotype predict lower psychological well-being. *Asian American Journal of Psychology, 13*(4), 339–350. https://doi.org/10.1037/aap0000291

Madan, S., Nanakdewa, K., Savani, K., & Markus, H. R. (2020). The paradoxical consequences of choice: Often good for the individual, perhaps less so for society? *Current Directions in Psychological Science, 29*(1), 80–85. https://doi.org/10.1177/0963721419885988

Markus, H. R., & Kitayama, S. (2010). Cultures and selves: A cycle of mutual constitution. *Perspectives on Psychological Science, 5*(4), 420–430. https://doi.org/10.1177/1745691610375557

Markus, H. R., Tsai, J. L., Uchida, Y., Yang, A., & Maitreyi, A. (2024). Cultural defaults in the time of COVID: Lessons for the future. *Psychological Science in the Public Interest, 25*, 41–91.

Mills, D. (2020). C.D.C recommends wearing masks in public; Trump says 'I'm choosing not to do it.' *The New York Times*. https://nytimes.com/2020/04/03/world/coronavirus-news-updates.html.

Morling, B., Kitayama, S., & Miyamoto, Y. (2002). Cultural practices emphasize influence in the United States and adjustment in Japan. *Personality and Social Psychology Bulletin, 28*(3), 311–323. https://doi.org/10.1177/0146167202286003

Nishimura, Y. (2020, September 18). 西村内閣府特命担当大 臣記者会見要旨　令和2年9月18日 [Nishimura Cabinet Office Special Minister in charge of press conference summary September 18, 2020]. Cabinet Office, Government of Japan. https://www.cao.go.jp/minister/2009_y_nishimura/kaiken/20200918kaiken.html.

Office of the President, Republic of China (Taiwan). (2020). President Tsai responds to Wuhan coronavirus outbreak, convenes high-level national security meeting to issue disease prevention directives. https://english.president.gov.tw/News/5967.

Salvador, C. E., Kamikubo, A., Kraus, B., Hsiao, N.-C., Hu, J.-F., Karasawa, M., & Kitayama, S. (2022). Self-referential processing accounts for cultural variation in self-enhancement versus criticism: An electrocortical investigation. *Journal of Experimental Psychology: General, 151*(8), 1904–1918. https://doi.org/10.1037/xge0001154

Sashin, D. (2020). Portraits on COVID-19 protective gear reveal human faces providing care. *Stanford Medicine Scope*. https://scopeblog.stanford.edu/2020/04/10/portraits-on-covid-19-protective-gear-reveal-human-faces-providing-care/.

Simmons-Duffin, S. (2021). *The NIH director on why Americans aren't getting healthier, despite medical advances*. NPR. https://www.npr.org/sections/healthshots/2021/12/07/1061940326/the-nih-director-on-whyamericans-arent-getting-healthier-despite-medical-advanc.

Thaler, R. H., & Sunstein, C. R. (2008). *Nudge: Improving decisions about health, wealth and happiness*. Yale University Press.

Tsai, J. L., Chen, D. S., Yang, A. M., Cachia, J. Y. A., Blevins, E., et al. (2025). *Two decades of ideal affect: Enduring cultural patterns and emerging associations*. Department of Psychology, Stanford University [Manuscript submitted for publication].

Tsai, J. L., Knutson, B., & Fung, H. H. (2006). Cultural variation in affect valuation. *Journal of Personality and Social Psychology, 90*(2), 288–307. https://doi.org/10.1037/0022-3514.90.2.288
Uchida, Y., & Kitayama, S. (2009). Happiness and unhappiness in East and west: Themes and variations. *Emotion, 9*(4), 441–456. https://doi.org/10.1037/a0015634
Uchida, Y., & Rappleye, J. (2024). *An interdependent approach to happiness and well-being*. Palgrave Macmillan. https://doi.org/10.1007/978-3-031-26260-9
U.S. Embassy Tbilisi. (2020). Remarks by President Trump on vaccine development (May 15). https://ge.usembassy.gov/remarks-by-president-trump-on-vaccine-development-may-15.
Vasquez, M., & Kelly, C. (2020). *Trump says coronavirus will 'disappear' eventually*. CNN. https://www.cnn.com/2020/02/27/politics/trump-coronavirus-disappear/index.html.
Ward, J. A., Stone, E. M., Mui, P., & Resnick, B. (2022). Pandemic-related workplace violence and its impact on public health officials, March 2020-January 2021. *American Journal of Public Health, 112*(5), 736-746. https://doi.org/10.2105/AJPH.2021.306649.
Yamaguchi, M. (2021). Why Japan has been slow to roll out vaccinations. *AP News*. https://apnews.com/article/japan-coronavirus-pandemicsports-business-04eaae220abeff6cb30ee4f0e0fc58f8.
Zell, E., Strickhouser, J. E., Sedikides, C., & Alicke, M. D. (2020). The better-than-average effect in comparative self-evaluation: A comprehensive review and meta-analysis. *Psychological Bulletin, 146*(2), 118–149. https://doi.org/10.1037/bul0000218