

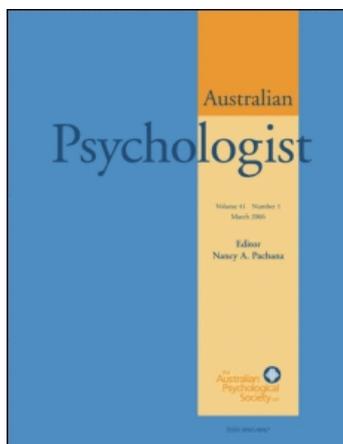
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### Disadvantages of being an individualist in an individualistic culture: Idiocentrism, emotional competence, stress, and mental health

Greg Scott <sup>a</sup>; Joseph Ciarrochi <sup>a</sup>; Frank P. Deane <sup>b</sup>

<sup>a</sup> Department of Psychology, University of Wollongong, Wollongong, New South Wales, Australia <sup>b</sup>

Department of Illawarra Institute for Mental Health, University of Wollongong, Wollongong, New South Wales, Australia

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## Disadvantages of being an individualist in an individualistic culture: Idiocentrism, emotional competence, stress, and mental health

GREG SCOTT<sup>1</sup>, JOSEPH CIARROCHI<sup>1</sup>, & FRANK P. DEANE<sup>2</sup>

<sup>1</sup>Department of Psychology and <sup>2</sup>Illawarra Institute for Mental Health, University of Wollongong, Wollongong, New South Wales, Australia

### Abstract

Based on past cross-cultural research, it was hypothesised that people who had strong individualistic values and beliefs within an individualistic culture would have smaller social support networks, lower emotional competence, lower intentions to seek help from a variety of sources, and poorer mental health. A total of 276 first-year students attending an Australian university completed an anonymous survey assessing individual differences in individualism (i.e., idiocentrism), social support, emotional competence, hopelessness, depression, and suicide ideation. As expected, idiocentrism was associated with smaller and less satisfying social support networks, less skill in managing both self and others' emotions, lower intentions to seek help from family and friends for personal and suicidal problems, and higher levels of hopelessness and suicide ideation. Thus, there appear to be social and psychological disadvantages associated with having strong individualistic values and beliefs within an individualistic culture. The implications of these findings for health promotion programs in schools and communities are discussed.

Cross-culturally, individualism is characterised by an independent self-construal, emotional independence, and behaviour regulated by the individual's attitudes, whereas collectivism is characterised by an interdependent self-construal, emotional interdependence, and behaviour regulated by in-group norms (Markus & Kitayama, 1991; Triandis, 1989; Triandis, 1995). Although associated with creativity, economic development, and freedom, individualists tend to be competitive, achievement focused, and devalue the role of interpersonal relatedness (Triandis et al., 1986; Triandis, Bon-tempo, Villareal, Asai, & Lucca, 1988). Individualists are also less likely to subordinate personal goals to group goals. This can lead to conflict and psychological distress, but this confrontation is accepted as a part of life (Triandis, McCusker, & Hui, 1990).

Researchers from a variety of disciplines have voiced concern that rising rates of depression and suicide, coinciding with a general decline in the quality of society's social fabric, may be related to

cultural values of individualism (Chen, 1996; Diener & Suh, 1999; Durkheim, 1897/1951; Eckersley, 1995; Myers, 1999; Schwartz, 2000; Triandis et al., 1988). For example, Durkheim suggested in 1897 that "excessive individualism not only results in favouring the action of suicidogenic causes, but is itself such a cause" (1897/1951, p.210). More recently, Eckersley (1995) reported higher suicide rates in the most individualistic countries, suggesting later (Eckersley, 2001) that some Western societies have promoted individualism to the point where it is becoming socially dysfunctional. Consistently, Schwartz (2000) attributes rapidly rising rates of depression in the USA to increasing societal individualism. Similarly, higher rates of depression have been reported in Western compared with Asian cultures (Chen, 1996). Triandis et al. (1988) suggest that social pathology is increasing in many countries as they become more individualistic, while in a review of relationships and quality of life, Myers (1999, p.387) stated that "... as the collapse of communism shows the failure of extreme collecti-

vism, so the American social recession shows the failure of extreme individualism.”

In contrast to findings that societal individualism is associated with lower levels of wellbeing, cross-culturally, individualism has also been associated with higher levels of subjective wellbeing (SWB), including happiness, life satisfaction and quality of life (Diener, Diener, & Diener, 1995; Diener & Suh, 1999; Veenhoven, 1999). For example, Diener et al. (1995) reported a strong correlation between societal individualism and SWB ( $r = .77$ ), while in a review of quality of life in 43 nations, Veenhoven (1999) reported a strong positive relationship between societal individualism and quality of life, suggesting that “the more individualized society, the happier its citizens are” (p.170). Indeed, in response to communitarian claims that neo-individualism in modern Western societies promotes social decay, isolation and anomy, Veenhoven (1999) goes so far as to suggest “that individualized society fits human nature better than collectivist society does” (p. 176) and questions “why so many eminent scholars are wrong” (p.175) in suggesting that individualism is detrimental to health and wellbeing.

Despite such assertions (e.g., Veenhoven, 1999), Diener and Suh (1999) acknowledge that although associated with higher levels of SWB, societal individualism is also associated with higher levels of suicide. Further, SWB is said to be highest in countries where SWB is thought to be important, while individualists tend to value happiness to a greater extent than do collectivists. As such, findings that suggest that members of individualistic societies are happier and more satisfied with life relative to members of collectivist societies may simply reflect the importance attributed to happiness and life satisfaction in individualistic society. Alternatively, such differences may be explainable in terms of the third variable hypothesis. That is, that SWB is also associated with increased national wealth which, in turn, is associated with higher levels of individualism. Given the high intercorrelations between national wealth and individualism, for example, their separate effects on SWB are yet to be isolated (Diener & Suh, 1999).

Although somewhat ambiguous, this cross-cultural research suggests that there may be some adverse consequences to having strong individualistic values and beliefs. However, the aforementioned research does not address this hypothesis specifically at the individual level of analysis. That is, do the adverse consequences observed cross-culturally also occur within a culture? Analogous to cross-cultural differences in individualism/collectivism (I/C), individuals within a given culture also vary in the degree to which they value either individualism or collectivism,

referred to as idiocentrism/allocentrism (i/A) respectively (Triandis, 1995, Triandis, Leung, Villareal, & Clack, 1985). Thus, one may be more or less idiocentric within either an individualist or a collectivist culture.

While some research has examined within-culture variations in i/A (e.g. Lay et al., 1995; Sinha & Verma, 1994; Triandis et al., 1988; Verkuyten & Lay, 1998; Yamaguchi, Kuhlman, & Sugimori, 1995), it has not yet fully explored the potential difficulties that might be associated with being a strong individualist within an individualistic culture, particularly in relation to psychological wellbeing. Thus, the present study sought to determine whether higher levels of individualism within a predominantly individualistic culture (idiocentrism) were associated with low emotional competence (i.e., emotion perception and management), less social support, less intention to seek help in times of turmoil and, consequently, poorer mental health.

We expect that the detrimental effect of individualistic values will be particularly apparent within an individualistic culture such as that of Australia (Triandis, 1989; Triandis, Chen, & Chan, 1998) for two primary reasons. First, there are more individualists within an individualistic culture (Kagitcibasi, 1994). Second, interpersonal relatedness and social exchange is valued to a lesser extent in individualist compared with collectivist cultures. Thus, the effect of having strong individualistic values is likely to be exacerbated in an individualistic culture.

### **Idiocentrism/allocentrism, social support, and psychological wellbeing**

Social and emotional separation is a fundamental characteristic of individualism, and of idiocentrism. However, an extensive literature supports the positive relationship between social support and psychosocial health (for good reviews see Barnett & Gotlib, 1988; Robinson & Garber, 1995; Uchino, Cacioppo, & Kiecolt-Glaser, 1996). Both quality and quantity of social support have been associated with lower levels of depression (Clarke & Jensen, 1997). Social support has been shown to act as a protective factor against stress and suicide (Kalafat, 1997). House, Landis, and Umberson (1988, p.540) suggest that, “prospective studies, which control for baseline health status, consistently show increased risk of death among persons with a low quantity, and sometimes low quality, of social relationships”. And, with regard to culture, Triandis et al. (1986, p.258) suggest that “the impact of negative life events appears to be stronger in individualist cultures and among idiocentrism than in collectivist cultures and among allocentrism because in collectivist

cultures social support systems are well developed". Thus, we expect idiocentrics to have smaller and less satisfying social support networks and, consequently, lower levels of social and emotional health. This hypothesis will be assessed by evaluating the mediating role of social support (amount and satisfaction) in relation to hopelessness, depression, and suicide ideation.

A number of studies have examined the association between i/A and various aspects of social support and psychological wellbeing. Allocentrism has been associated with higher life satisfaction among youth of Chinese (collectivist) origin living in The Netherlands (Verkuyten & Lay, 1998). It has been associated with higher private collective self-esteem (e.g., feeling good about the ethnic group you belong to) and public collective self-esteem (e.g., believing that other people respect your group) among college students at a U.S. Midwestern university (Bettencourt & Dorr, 1997), and higher private collective self-esteem but not higher public collective self-esteem among a Chinese sample (Verkuyten & Lay, 1998). Allocentrics have been found to have higher affiliative tendencies and less need for uniqueness, although higher sensitivity to rejection, within samples in the USA, Korea, and Japan (Yamuguchi et al., 1995). Finally, allocentrism in the USA has been shown to relate to high quality and quantity of social support (Triandis, et al., 1985; Triandis et al., 1988), and to low levels of loneliness (Triandis et al., 1988).

Few studies have focused on how i/A relates to mental health. One such study found that allocentric values towards the family ("knowing that I can rely on my family makes me happy") appeared to decrease the adverse impact of stress on depressive symptoms among Vietnamese living in Canada (Lay et al., 1998). Another study in India found that allocentrics reported a greater sense of psychological wellbeing, but only if they had high quality social support (Sinha & Verma, 1994). Importantly though, the samples utilised in these two studies vary significantly from our proposed sample. That is, Lay et al. (1998) examined variations in i/A among collectivists living in an individualist culture, while Sinha and Verma (1994) examined variations in i/A among collectivists living in a collectivist culture. Thus, the present study aims to extend previous research by examining variations in i/A among individualists within an individualistic culture to determine whether idiocentrism is related to depression, hopelessness, and suicide ideation, and whether any observed relationships are moderated by the quality of social support. We will also assess life stress, and explore the possibility that idiocentrism will increase the adverse impact of stress on depressive symptoms, as was found by Lay et al.

(1998). However, in light of the potential interaction between individual and cultural levels of analyses (Berry, 1994), we do not expect to witness the same pattern of relations between idiocentrism and mental health as found by Lay et al. (1998) and Sinha and Verma (1994). For example, given that social exchange is a fundamental aspect of living in a collectivist culture, idiocentrics in collectivist cultures are less likely to be adversely affected under conditions of low social support compared to idiocentrics in individualist cultures, because in individualist cultures the perception of available social support is contingent on the individual establishing such support networks.

### **Idiocentrism/allocentrism, emotional competence, and, intention to seek help**

Cultural (and subcultural) beliefs and customs profoundly influence the types of emotional experiences a child is exposed to, and thus socialised by (Saarni, 1999). Children taught strong allocentric beliefs, especially within individualistic cultures, are likely to experience more social/emotional interactions, and are more likely to attempt to establish and maintain strong social/emotional bonds with others (Berry, 1994; Kagitcibasi, 1994). We expect that this increased collectivist experience during childhood will help children to develop basic emotional competencies. Consistent with this view, adolescents with little social support have been shown to have less emotional competence (Ciarrochi, Chan, & Caputi, 2000).

There have been a substantial number of emotional competencies identified by different researchers (Ciarrochi et al., 2000; Ciarrochi & Deane, 2001; Mayer & Geher, 1996; Salovey & Mayer, 1990; Salovey, Mayer, Goldman, Turvey, & Palfai, 1995). Four competencies in particular appear to be important in understanding how well people deal with stress and avoid poor mental health outcomes: Perceiving Emotions, Managing Self-Relevant Emotions, Managing Others' Emotions, and Intentions to Seek Help when in emotional need (Ciarrochi & Deane, 2001; Ciarrochi, Deane, & Anderson, 2002).

Relatively little work has focused on the relationship between individualism (or idiocentrism) and emotional competence. One such study provided some evidence that individualism (among Chinese Americans) is associated with lower intentions to seek help from professional sources (Tata & Leong, 1994). The present study will extend this past research by examining the impact of idiocentrism on the intention to seek help from a variety of professional (e.g., help line, mental health professional) and nonprofessional (e.g., family, friends) sources. Given that Intention to Seek Help combines

both knowledge (e.g., having an accurate understanding of the benefits and costs of help seeking) and attitude (e.g., hating the idea of having to seek help), we expect idiocentrics to show less intention to seek help for personal and/or suicidal problems.

### **Idiocentrism/allocentrism and wellbeing: Is it more than social support?**

Social support is of significant benefit to mental health (Barnett & Gotlib, 1988; Robinson & Garber, 1995). If our hypothesis that those who value idiocentrism will have poorer mental health is confirmed, to what extent are these deficits explained by social support? Previous research has shown that allocentrics are more likely to gain satisfaction and self-esteem through the mere act of identifying with a group (Bettencourt & Dorr, 1997; Verkuyten & Lay, 1998), perhaps even if that group does not provide them with support for their personal problems. Thus, we expect there to be detrimental effects associated with having idiocentric values that cannot simply be explained in terms of social support. This possibility will be assessed by examining the relationship between idiocentrism and mental health while controlling for the amount and quality of social support.

## **Method**

### *Participants*

The participants consisted of 276 first-year students attending an Australian university, who participated in this study for course credit. The 222 female students and 54 male students were aged between 16–48 years, with a mean age of 21.6 ( $SD = 6.0$ ). Twenty participants (7%) born in collectivist countries such as Hong Kong, Japan, Korea, and Chile, were excluded from the main analyses because of their small, heterogenous, and thus unreliable nature as a comparative cultural sample.

### *Measures and procedure*

Participants completed an anonymous questionnaire containing a number of measures assessing individualism, social support, emotional competence, stress and psychological wellbeing. Participants also provided information pertaining to their sex, age and cultural background. The full questionnaire took approximately 50 min to complete.

### *Individualism and collectivism*

We used a multimethod approach to assess individualism/collectivism in our sample (Triandis, Chan,

Bhawuk, Iwao, & Sinha, 1995). One method (rating scale) involved presenting participants with a 13-item scale (Triandis et al., 1995), which assessed the behavioural intentions of an individual in situations involving family and friends. For example, participants were asked to indicate the extent to which they viewed themselves as the type of person who would ask their old parents to live with them, or would entertain even unwelcome guests. Responses were given on a 9-point scale with *true* (1) and *false* (9) as anchors. The second forced choice method utilised 16 scenarios in which participants were presented with questions such as “Suppose you had one word to describe yourself. Which one would you use?” Participants would then rank two of four options in order of preference. The aforementioned example included, “unique, competitive, cooperative, and dutiful,” representing vertical individualism, horizontal individualism, horizontal collectivism, and vertical collectivism respectively (Triandis et al., 1998; Triandis & Gelfand, 1998).

In order to form the I/C scale, all scores from both scales were first converted to Z-scores. A principal components factor analysis was conducted to evaluate whether all items loaded on what might be labelled an individualism/collectivism factor in our Australian sample. All but three items loaded in the expected direction on the first principal component, which we labelled general preference individualism (GPI: or the extent that individualism is preferred over collectivism). Items that loaded positively on the first principal component and had a loading above .16 were retained for a revised scale. Ten items were taken from the forced choice scale and 10 items from the rating scale (five individualist and five reverse-scored collectivist items). The reliability of this total scale was adequate for research purposes ( $\alpha = .62$ ), although somewhat less than desirable.

### *Stress*

Psychological stress was measured using two scales, the Life Experiences Survey (LES; Sarason, Johnson, & Siegal, 1978) and the Hassles Scale (HAS; Kanner, Coyne, Schaefer, & Lazarus, 1981). In the LES, participants were asked to indicate the occurrence of any of 57 experiences and three (optional) participant-specific experiences in the past 6 months and/or 1 year. Participants were also instructed to rate each of these experiences as having either a negative or a positive impact on them on a 7-point Likert scale ranging from –3 to 3.

The Hassles Scale (Kanner et al., 1981) is a 117-item inventory that assesses the frustration and irritation of everyday encounters that can range from minor annoyances to major problems or difficulties. Participants were asked to circle the hassles that had

happened to them in the past month on a 3-point Likert scale ranging from 1 (*somewhat severe*) to 3 (*extremely severe*).

#### *Depression, hopelessness, and suicide ideation*

Depression was measured using the 21-item Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), which assesses cognitive ("I feel sad"), behavioural ("I sleep more than I used to") and somatic ("I have less energy than I used to") aspects of depression that have occurred in the past 2 weeks. Items were rated on a 4-point scale (0–3), with higher scores indicating depression. The validity of the BDI is well established in both clinical and nonclinical populations (Clark & Beck, 1991).

The Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, & Trexler, 1974) is a 20-item scale for which participants respond *true* or *false* to each item to reflect their negative expectations and pessimism regarding the future. The BHS has high levels of internal consistency (K-R 20 = .89) (Weishaar, 1996) and acceptable concurrent validity (Cole & Milstead, 1989). The BHS has been used in a variety of studies on depression and suicide (Cole & Milstead, 1989), and has utility in the prediction of eventual suicide (Weishaar, 1996).

Suicide ideation was measured using the 30-item Suicide Ideation Questionnaire (SIQ; Reynolds, 1987), which assesses one's thoughts about suicide in the past month, for example, "I thought it would be better if I were not alive". The SIQ is scored on a 7-point Likert scale ranging from 1 (*I have never had this thought*) to 7 (*I have this thought almost every day*). The SIQ has high reliability,  $\alpha = .96$ , is related to depression, hopelessness and negative life events, and predicted 65% of the variance in suicidality in one sample of students (Reynolds, 1987).

The scores on the suicide ideation questionnaire were severely skewed in the present data set (skewness statistic = 2.32,  $SE = 0.15$ ). To correct for this problem, suicide ideation scores were converted to ranks. The depression and hopelessness scores were much less skewed, skewness statistic = 0.97,  $SE = 0.15$ , skewness statistic = 1.5,  $SE = 0.15$ , respectively. Converting these scores to ranks had no effect on the tests reported below. Thus, for the sake of simplicity, results for the untransformed hopelessness and depression scales are reported.

#### *Social Support*

Social Support was measured using a shortened version of the Social Support Questionnaire (SSQ; Sarason, Levine, Basham, & Sarason, 1983). This consisted of four items, such as "Whom could you

count on to help you out in a crisis situation, even though they would have to go out of their way to do so?" For each item participants were asked to list the initials of the people they can rely on, their relationship to them, and their overall satisfaction with the support available to them. This reduced version of the SSQ was highly reliable:  $\alpha = .85$  for amount of support, and  $\alpha = .84$  for quality of support.

#### *Emotional Competence*

The self-report emotional competence questionnaire by Schutte et al. (1998) comprises 33 self-referencing statements and requires subjects to rate the extent they agree or disagree with each statement on a 5-point scale (1, *strongly disagree*; 5, *strongly agree*). A number of studies has supported the validity of this measure (Ciarrochi, Chan, & Bajgar, 2001; Ciarrochi et al., 2002; Ciarrochi & Deane, 2001; Schutte et al., 1998). The scale yields an overall emotional intelligence score ( $\alpha = .86$ ) and can be further broken down into three factors (Ciarrochi et al., 2002). The perception factor (10 items;  $\alpha = .81$  in this sample) consists of statements such as "I find it hard to understand the nonverbal messages of other people". The Managing Self-Emotions (MSE) factor (9 items;  $\alpha = .77$ ) consists of items such as "I motivate myself by imagining a good outcome to tasks I take on". The Managing Others' Emotions (MOE) factor (8 items;  $\alpha = .68$ ) consists of items such as "I arrange events others enjoy".

#### *Help Seeking*

The General Help Seeking Questionnaire (GHSQ; Deane, Wilson, & Ciarrochi, 2001) was developed to formally assess intentions to seek help for personal and suicidal problems and has been shown to predict actual help-seeking behaviour (Deane, Ciarrochi, Rickwood, & Anderson, 2001). Participants rated the likelihood they would seek help for two problem types: personal–emotional and suicidal thoughts, on a 7-point scale (1, *extremely unlikely*, to 7, *extremely likely*), from six sources of help: friend, parent, other relative/family member, mental health professional, phone help line, and doctor/general practitioner (GP). Participants were also asked if they would seek help from an intimate partner (e.g., boyfriend) if they have one, and if they would not seek help from anyone for each problem type.

The GHSQ was reduced to form four major subscales: Intentions to Seek Help From Family and Friends (6 items;  $\alpha = .81$ ); Intentions to Seek Help from Professionals (6 items;  $\alpha = .85$ ); Intentions to Seek Help From an Intimate Partner (which applied to only a subset of our sample); and, Refusal to Seek Help From Anyone.

## Results

### Preliminary analyses

*Descriptive statistics.* We first sought to gain a better understanding of the cultural profile of our sample by examining the forced choice scenario measure independently. Consistent with Triandis et al. (1998), we calculated the average percentage of responses for each of the four categories represented in the 16 scenarios, that is, vertical individualism (VI), horizontal individualism (HI), horizontal collectivism (HC), and vertical collectivism (VC). Based on first preferences, the profile of our sample is  $HI > HC > VI > VC$  (43%, 32%, 15%, and 10%, respectively), which is consistent with the Australian profile reported by Triandis et al. (1998). We also calculated an overall score for each participant by giving 2 points for each first preference and 1 point for each second preference. Thus, scores could range between 48 and 192 and participants could be broadly classified as endorsing either VC (48–84 points), HC (85–120 points), HI (121–156 points), or VI (157–192 points). In our sample, scores ranged from 105 to 147 ( $M = 124.6$ ,  $SD = 7.9$ ), with 68.4% of respondents indicating a preference for HI and 31.6% of respondents indicating a preference for HC. Looking at the data separately for sex, 84.3% of male respondents compared to 64.4% of female respondents would be classified as endorsing HI, with the remaining 15.7% and 35.6% of male respondents and female respondents, respectively, endorsing HC.

Descriptive statistics for the dependent variables are as follows: depression ( $M = 0.61$ ,  $SD = 0.41$ ), hopelessness ( $M = 1.2$ ,  $SD = 0.17$ ), suicide ideation ( $M = 1.65$ ,  $SD = 0.70$ ), stress ( $M = 55.5$ ,  $SD = 38.2$ ), social support amount ( $M = 22.8$ ,  $SD = 7.7$ ), social support satisfaction ( $M = 5.2$ ,  $SD = 0.73$ ), overall emotional competence ( $M = 3.7$ ,  $SD = 0.39$ ), emotion perception ( $M = 3.6$ ,  $SD = 0.59$ ), manage own emotions ( $M = 3.7$ ,  $SD = 0.52$ ), manage others' emotions ( $M = 3.7$ ,  $SD = 0.51$ ), personal help seeking ( $M = 4.3$ ,  $SD = 1.5$ ), professional help seeking ( $M = 3.2$ ,  $SD = 1.6$ ), intimate help seeking ( $M = 5.3$ ,  $SD = 1.7$ ,  $n = 196$ ), refuse to seek help ( $M = 2.6$ ,  $SD = 1.9$ ).

### Sex and age

A one-way analysis of variance (ANOVA) was used to determine whether sex was related to any of our independent or dependent variables. Female respondents reported higher levels of depression ( $M_{men} = 0.48$ ,  $M_{women} = 0.64$ ,  $F(1,251) = 6.1$ ,  $MSW = 0.99$ ,  $p = .014$ ), while male respondents reported being better able to manage their own emotions ( $M_{men} = 3.9$ ,  $M_{women} = 3.6$ ,  $F(1,254) = 8.4$ ,

$MSW = 2.2$ ,  $p = .004$ ). Male respondents also reported endorsing idiocentrism to a greater extent than female respondents ( $M_{men} = 0.15$ ,  $M_{women} = -0.03$ ,  $F(1,254) = 11.5$ ,  $MSW = 1.4$ ,  $p = .001$ ). We also examined correlations between age and our outcome variables. A significant negative correlation was evident between age and idiocentrism ( $p = .001$ ), while age was positively associated with overall emotional competence ( $p = .003$ ), emotion perception ( $p = .011$ ), intention to seek help from a professional ( $p < .001$ ), and from an intimate partner ( $p = .001$ ). All other relationships were nonsignificant.

### Correlation analyses

Table I (middle column) presents the correlations between idiocentrism and our outcome measures. As expected, idiocentrism was significantly associated with smaller and less satisfying social support networks and lower overall emotional competence, including less competence at managing one's own and others' emotions. Although unrelated to depression, idiocentrism was associated with higher levels of hopelessness and suicide ideation (converted to rank). Idiocentrism was also associated with lower intentions to seek help from family and friends and from an intimate partner, and higher intentions to refuse help from everybody, for personal and suicidal problems. There was no relationship between

Table I. Relationship between idiocentrism and, social support, stress, emotional competence, mental health, and intention to seek help

	Individualism (No controls)	Individualism (Controlling Social Support)
Social Support		
Amount	-.30***	-
Satisfaction	-.14*	-
Stress		
Daily Hassles	-.02	-.03
Major Life Events	-.07	-.03
Emotional Competence		
Overall Competence	-.13*	-.05
Perception	-.06	-.02
Managing Others' Emotions	-.11*	-.03
Managing Own Emotions	-.18**	-.10
Intention to Seek Help		
From Family and Friends	-.29***	-.21***
From Professionals	-.01	.05
From Intimate Partner	-.20**	-.15*
Not Seek Any Help	.29***	.26***
Mental Health		
Depression	.00	-.10
Hopelessness	.21***	.14*
Suicide Ideation (rank)	.12*	.07

Note. \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ , one-tail tests.

idiocentrism and stress, emotion perception, or intentions to seek help from a professional.

We also evaluated whether the observed relationships involving idiocentrism held, even after controlling for social support (amount and satisfaction). As can be seen in Table I (right column), even after controlling for social support, idiocentrism was still related with more hopelessness and lower intentions to seek help from family, friends and an intimate partner, and higher intentions to refuse help from everyone. However, the relationship between idiocentrism and overall emotional competence, one's ability to manage one's own and others' emotions, and suicide ideation were no longer significant, suggesting that these relationships could be explained in terms of social support.

### Mediation analyses

We next sought to establish if social support mediated the role between idiocentrism and mental health. Three conditions must be satisfied to establish evidence of mediation. First, the independent variable must be significantly related to the dependent variable (Table I, hopelessness and suicide ideation satisfy this condition). Second, the independent variable must be significantly related to the proposed mediator (Table I, social support amount and satisfaction satisfy this condition). Third, the proposed mediator must affect the dependent variable while controlling for the independent variable. Partial mediation is in evidence if the relationship between the independent and dependent variable is significantly reduced, while full mediation is in evidence if this relationship is reduced to zero, when controlling for the proposed mediator (Baron & Kenny, 1986). We therefore conducted four regression analyses to evaluate the mediating role of social support (amount and satisfaction) in relation to idiocentrism and, hopelessness and suicide ideation. Social support amount appeared to fully mediate the relationship between idiocentrism and hopelessness (social support:  $\beta = -.021$ ,  $p < .001$ ; idiocentrism:  $\beta = -.065$ ,  $p = .033$ ) and suicide ideation (social support:  $\beta = 6.09$ ,  $p = .017$ ; idiocentrism:  $\beta = 14.08$ ,  $p = .30$ ). And social support satisfaction partially mediated the relationship between idiocentrism and hopelessness (social support:  $\beta = -.047$ ,  $p = .001$ ; idiocentrism:  $\beta = -.085$ ,  $p = .004$ ) and fully mediated the relationship between idiocentrism and suicide ideation (social support:  $\beta = 23.04$ ,  $p < .001$ ; idiocentrism:  $\beta = 17.5$ ,  $p = .18$ ).

### Moderation analyses

Baron and Kenny (1986) describe a moderator as a qualitative or quantitative variable that affects the

strength and/or direction of the relation between an independent and dependent variable. Moderation is in evidence if the interaction between the independent and moderating variable is significant. Thus, in order to determine whether social support moderated the relationship between idiocentrism and well-being, six general linear model (GLM) univariate regression analyses were conducted. Idiocentrism, social support (separate analyses for amount of, and satisfaction with, social support), and the interaction between these two variables were used to predict hopelessness, depression, and suicide ideation. To reduce the likelihood of a Type I error, interactions were considered significant at  $p \leq .01$ . Although approaching significance in the prediction of hopelessness ( $p = .039$ ), there were no significant interaction effects (all  $F < 4.3$ , all  $p > .039$ ). Thus social support did not significantly moderate the relationship between idiocentrism and mental health in our Australian sample.

Finally, we examined whether idiocentrism increased the adverse impact of stress on depressive symptoms, as was found by Lay et al. (1998). Idiocentrism, stress (separate analyses for daily hassles and major life events), and the interaction between idiocentrism and stress were used in two GLM univariate regression analyses to predict depression. Consistent with the findings reported by Lay et al. (1998), hassles were related to depression ( $F = 71.8$ ,  $p < .001$ ), although idiocentrism was not ( $F = 0.28$ ,  $p = .59$ ). However, in contrast to their findings, the interaction between idiocentrism and hassles was not significant ( $F = 0.61$ ,  $p = .43$ ). A similar pattern was also found for life events (life events:  $F = 21.7$ ,  $p < .001$ ; idiocentrism:  $F = 0.19$ ,  $p = .66$ ; interaction term:  $F = 0.39$ ,  $p = .55$ ). Thus, idiocentrism did not moderate the relationship between stress and depressive symptoms in our sample.

### Discussion

As expected, higher levels of individualism within an individualistic society were associated with a number of social and psychological disadvantages. Idiocentrics had smaller and less satisfying social support networks, low emotional competence, poorer mental health indicators and lower intentions to seek help in times of need. Many of these relationships held even after controlling for the social support variables, suggesting that the relationship between idiocentrism and the outcome measures could not be explained entirely by differences in social support. There was no link between idiocentrism and amount of life stress, and idiocentrism did not moderate the link between stress and depression. Somewhat surprisingly, the link between idiocentrism and

hopelessness was not moderated by social support, which is inconsistent with past research (Sinha & Verma, 1994). That is, idiocentrists in our sample tended to feel more hopeless than allocentrists regardless of how much social support they had. Finally, social support (amount and satisfaction) appeared to mediate the relationship between idiocentrism and, hopelessness and suicide ideation, suggesting a causal relationship between idiocentrism and these aspects of mental health.

#### *Idiocentrism, social support, and mental health*

Idiocentrism was related to hopelessness and suicide ideation, but was not related to depression. Thus, idiocentrism was linked less with emotional states than it was with the more cognitive states associated with low expectations about the future and the desire to “give up”. This effect held even after controlling for social support. What is it beyond social support that leads idiocentrists to feel more hopeless? One possibility is that idiocentrists may be less likely to gain a sense of meaning, positive emotions, and self-esteem through identifying with groups (ethnic group, family, etc.). Consistent with this view, research has shown that idiocentrists have lower collective self-esteem (Bettencourt & Dorr, 1997; Verkuyten & Lay, 1998). Future research will be needed to determine whether the construct of collective self-esteem can be used to explain the relationship between idiocentrism and hopelessness.

Social support amount appeared to fully mediate the role between idiocentrism and, hopelessness and suicide ideation, while social support satisfaction partially mediated these relationships. Consistent with our view that idiocentric values and beliefs precede the development and acquisition of social support networks, this finding is consistent with a causal relationship between idiocentrism and social support, and subsequent mental health outcomes. That is, idiocentrism appears to cause lower social support, which, in turn, causes poorer mental health outcomes. However, given the correlational nature of this study, future developmental or experimental research is needed to clarify this finding.

Contrary to the research of Lay et al. (1998), idiocentrism did not moderate the relationship between stress and depression. Nor was the relationship between idiocentrism and hopelessness moderated by amount of social support, which is inconsistent with the findings of Sinha and Verma (1994). It is important to note that our sample (generally individualists within an individualistic culture) was fundamentally different from the Lay et al. sample (collectivists within an individualistic culture) and the Sinha and Verma sample (generally collectivists within a collectivistic culture). It is

possible that the relationship between idiocentrism and our various outcome measures depends on an interaction between individual and cultural level factors (Berry, 1994; Kim, Triandis, Kagitcibasi, Choi, & Yoon, 1994). For example, Asians in their own collectivist cultures have reported less depression than do people from Western cultures (Chen, 1996), whereas Asians living in an individualistic culture have reported greater levels of depression than their Western counterparts (e.g., Aldwin & Greenberger, 1987). People originating from collectivist cultures with relatively idiocentric personal values tend to adapt more easily to the demands of living in an individualistic host culture relative to those with allocentric values (Berry, 1994). This may be, in part, because independence is more consistent with the demands of contemporary individualistic society. Thus, the effect of being a collectivist, or an individualist, and coinciding variations in i/A, may depend critically on both the culture of origin and residence.

#### *Idiocentrism and emotional competence*

Idiocentrism was associated with lower levels of overall emotional competence and was associated with the emotional competence subscales of Managing Own Emotions and Managing Others' Emotions. However, it was not related to emotion perception. One possible, but admittedly speculative, explanation for this finding is as follows. Triandis et al. (1990, p.1009) argue that, “because individualists must enter and leave many in-groups, they develop superb skills for superficial interactions, but do not have very good skills for intimate behaviors”. Numerous superficial interactions may give idiocentrists the experience they need to perceive emotions accurately, at least as well as allocentrists. However, it may be that intimate interactions provide allocentrists with more opportunities to develop their emotion management skills. Future research will be needed to evaluate this intriguing possibility.

Idiocentrism was no longer significantly related to the emotional competencies after controlling for social support. This finding is consistent with the notion that people high in idiocentrism are low in emotional competence in part because they have less social support. There are several ways in which social support may relate to emotional competence. Those who are more emotionally competent may have the necessary skills to be able to attract more social support, and/or those high in social support may have more intimate social interactions and therefore more opportunities to develop their emotional competencies. It is also possible that social support may directly improve emotional competence by

acting as a resource that people can use to help resolve their emotional problems. For example, allocentrics may rely on social supports such as close friends and family to help them to understand and manage their negative moods. Idiocentrics are less likely to have access to these social supports to help them manage their moods, and even when they have access to social support, they are less likely to utilise this support. Alternatively, idiocentrics may simply be less willing to develop their emotional competencies, particularly those relating to others', and in so doing, undermine their own emotional development and thus their ability to attract social support.

Finally, idiocentrism was associated with lower intentions to seek help from family and friends and intimate partners, and higher intentions to not seek help from anyone for personal and suicidal problems. Importantly, these effects held, even after controlling for social support. Thus, idiocentrics reported little intention to seek help from others even when they had a lot of social support and were satisfied with that social support.

#### *Implications and future directions*

To some extent, training programs that emphasise "citizenship" and community responsibility may already be teaching people collectivist (allocentric) principles. The findings in the present study have implications for the development of these and other social competence programs (e.g., in schools). The results suggest that individuals may benefit from being taught to identify their individualist/collectivist beliefs, and to understand the implications of those beliefs for their social support, emotional competence, and mental health. Such programs might also target and eliminate dysfunctional individualistic beliefs (e.g., the belief that it is inappropriate to ever rely on others for help).

Although we have emphasised the detrimental effects of high levels of individualism (and idiocentrism), we acknowledge that high levels of collectivism (and allocentrism) may also be detrimental in certain contexts (Triandis & Gelfand, 1998). However, it may be difficult to find adverse effects of collectivism within our sample, given that the culture is predominantly individualistic. Even those who would be considered allocentric in our sample would be classified as individualistic cross-culturally, and thus considered relatively idiocentric in a collectivist culture. Future research is needed to evaluate whether our results generalise to a collectivist culture and, importantly, to collectivist subgroups (e.g., Asian Australians) within individualist cultures. Similarly, there are likely to be contexts where idiocentrism confers some benefits, and research also needs to include measures that might be

expected to highlight the benefits of idiocentrism. For example, idiocentrics may be less vulnerable to anxiety and depression that results from social rejection. Also, within-culture variation in individualism may be associated with greater individual creativity and economic success (Kim, 1994; Triandis et al., 1988).

While we would argue that idiocentric beliefs lead to poor social support, emotional competence, and mental health, a limitation of the present research is that it is correlational in nature and cannot therefore be used to infer the causal direction of the observed relationships. Although the mediation analyses provide evidence of causality, alternative causal models are also compatible with the data (e.g., lower social support may lead to greater idiocentric beliefs). However, it is still notable that even in a predominantly individualistic sample, higher levels of idiocentrism were associated with greater hopelessness.

A lack of social support could not account for this finding. In addition, idiocentrics were more likely to have had suicidal thoughts during the past month, and indicated that they were less likely to seek help when experiencing personal and/or suicidal problems. Although more research is needed to clarify the limits of these findings, the future challenge may be to balance the benefits of individualistic values such as achievement orientation and competitiveness while avoiding the apparent disadvantages to aspects of social and mental health.

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