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ARTICLE

When Personality and Culture Clash: The Psychological Distress of Allocentrics in an Individualist Culture and Idiocentrics in a Collectivist Culture

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Abstract Because humans need both autonomy and interdependence, persons with either an extreme collectivist orientation (allocentrics) or extreme individualist values (idiocentrics) may be at risk for possession of some features of psychopathology. Is an extreme personality style a risk factor primarily when it conflicts with the values of the surrounding society? Individualism–collectivism scenarios and a battery of clinical and personality scales were administered to nonclinical samples of college students in Boston and Istanbul. For students residing in a highly individualistic society (Boston), collectivism scores were positively correlated with depression, social anxiety, obsessive–compulsive disorder and dependent personality. Individualism scores, particularly horizontal individualism, were negatively correlated with these same scales. A different pattern was obtained for students residing in a collectivist culture, Istanbul. Here individualism (and especially horizontal individualism) was positively correlated with scales for paranoid, schizoid, narcissistic, borderline and antisocial personality disorder. Collectivism (particularly vertical

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collectivism) was associated with low report of symptoms on these scales. These results indicate that having a personality style which conflicts with the values of society is associated with psychiatric symptoms. Having an orientation inconsistent with societal values may thus be a risk factor for poor mental health.

Key words collectivism • individualism • personality • subclinical • well-being

Research on individualism and collectivism provides a framework for exploring the intersection of culture and mental health (Hui & Triandis, 1986; Kagitçibasi, 1997; Triandis, 2001). Members of individualistic cultures see themselves as autonomous agents motivated by their own preferences and goals (Hofstede, 1980; Hsu, 1960). Interactions with others are governed by a social contract or abstract universal principles of rights and responsibilities (Waterman, 1984). Collectivistic cultures encourage strong links among members of a social group, who subordinate personal needs for the good of the group, or choose goals which do not threaten group harmony (Hui & Triandis, 1986). Industrialized nations such as the United States, England, and Australia are regarded as individualistic while developing regions, such as Africa, China and areas of the Middle East, typically have traditional values and are collectivistic (Oyserman, Coon, & Kemmelmier, 2002).

Individualism/collectivism is thought to have widespread influence on how the relationship between the self and others is conceptualized. Collectivists consider themselves as similar to members of their ingroup (Iyengar, Lepper, & Ross, 1999), and make a strong boundary between ingroup and outgroup. Individualists see themselves as more differentiated and separate from other people, including family and friends. Individualists frequently think of self-reliance as being able to pursue their own goals, while for collectivists, self-reliance means not being a burden on one's ingroup (Triandis, 2001).

The cultural syndromes of individualism and collectivism are believed to have distinct advantages and disadvantages in promoting psychological health and wellbeing (Triandis & Gelfand, 1998). For example, individualism fosters the pursuit of self-actualization, but at the expense of social isolation (Triandis, 2001). Collectivism provides social support and feelings of belonging, but also brings anxiety about not meeting social obligations. Within a given culture, persons who have individualist traits (referred to as idiocentrics) value competition, hedonism and self-reliance. Persons who have a collectivist orientation (allocentrics) value tradition, sociability and interdependence (Schwartz, 1990). Researchers have speculated that extreme idiocentrism and allocentrism may also be

risk factors for poor mental health (Triandis, 2000), but no data yet exist on this topic.

We are sympathetic to these views, and feel they are broadly correct, but argue that there is an additional layer: Psychological adjustment depends on the degree of match between personality and the values of the surrounding society. We propose the personality–cultural clash hypothesis: Personality traits associated with psychopathology will be most frequent in allocentrics living in an individualist society, and in idiocentrics living in a collectivist society.

Later in the article we review proposals on how mental health may be influenced by individualism and collectivism. We begin with the critiques of American individualism which have appeared in the social science literature in the last decades. However, cross-cultural research has revealed that collectivist societies have their own vulnerabilities to psychopathology. With this as background, we will investigate our main hypothesis: Do idiocentrics' and allocentrics' scores on clinical scales (which tap psychological functioning) depend on whether they reside in an individualist or a collectivist country?

The Ills of Individualism

Over the last 40 years, authors have pointed to the increase in psychiatric syndromes and criminal deviancy in western industrialized countries, and have implicated western individualism as the culprit (Hsu, 1960; Lane, 2000; Lasch, 1991; Sampson, 1977; Spence, 1985; Wallach & Wallach, 1983). Individualist values such as competition, hedonism, and placing personal goals above group harmony are thought to underlie a range of social problems.

Some researchers have argued that family dysfunction is the most important variable responsible for the increase in antisocial behavior (Vaughn & Leff, 1976). Social ills may result from the reduction of social support and community cohesiveness engendered by an increasing focus on individual achievement (Gottfredson & Hirschi, 1990). As cultures move toward individualism, children receive less meaningful interactions with their parents (Paris, 1996). Indulgence and lack of control in parenting, combined with a society which promotes individual fulfillment, means that children and adults have little practice in impulse control (Horgan, 1975). Cooke (1996) went so far as to ask, 'Are we unknowingly allowing a society to evolve that is the perfect breeding ground and perhaps even a "killing field" for psychopaths?' (p. 27).

Other researchers have emphasized the lack of social cohesion in the community (Naroll, 1983). Paris (1996) introduced the 'social disintegration hypothesis' (p. 86), which proposed that socially cohesive societies

with clear standards of behavior protect their members from psychopathology. On this view, western individualism is not just responsible for antisocial deviance, but fosters depression and perhaps the full gamut of psychiatric disorders as well, a position echoed by several other authors (Lane, 2000; Lasch, 1991; Sampson, 1977; Spence, 1985).

Collectivist Cultures and Mental Health

The incidence of criminal and violent behavior is lower in cultures with collectivist traditions (Hwu, Yeh, Chang, & Yeh, 1989). However, the picture is mixed regarding major psychiatric disorders (Tanaka-Matsumi & Draguns, 1997). Hwu and colleagues (1989) found that Taiwan had a lower prevalence than the US of depression, dysthymia, alcoholism, antisocial personality disorder, cognitive impairment, schizophrenia, panic disorder, phobic disorder, and obsessive–compulsive disorder (OCD). Mania, generalized anxiety disorder, and somatization disorder were not less prevalent in Taiwan than in the US.

Collectivist and traditional cultures may create conditions which foster depression and anxiety. Collectivist socialization practices increase dependency and decrease autonomy. Persons are encouraged to subordinate personal goals to group agendas. African children tend to suffer from more internalizing disorders such as fearfulness, sleep disturbances and somatization while American children have more externalizing problems, such as conduct disorder (Weissman, 1993). Internalizing problems may arise when children are sensitive to parents' high level of control. Externalizing problems can be viewed as problems of under-control, as children are insufficiently sensitive to social expectations.

A potential disadvantage of collectivist child rearing is that it may undermine the self-esteem of the child, and lead to adults who are compliant but noninnovative, and have lower levels of happiness (Diener & Diener, 1995). Lower reports of subjective wellbeing in some collectivist cultures may reflect dissatisfaction with the burden of doing one's duty and the obstacles to achieving self-actualization. The negative consequence of collectivism is thus that being controlled by shame and guilt leads to anxiety about whether one can meet social obligations, and to depression, because shame and guilt interfere with pursuing one's own goals.

Advantages and Disadvantages of Individualism and Collectivism at the Societal Level

Rather than merely pointing out the negative aspects of individualist societies, many cross-cultural researchers have focused on the advantages

and disadvantages of individualism vs. collectivism (Triandis, 2001). Collectivism fosters practices and attitudes which are advantageous for small groups and interpersonal situations. Being able to depend on personal alliances, and to give and return cooperation from others, is advantageous in small groups. When dealing with a large collective, such as the state, individualism may be most advantageous, because then one can focus on one's own goals.

Triandis and Gelfand (1998) discussed how collectivism and individualism can be distinguished according to the vertical and horizontal organization of societies, yielding four cultural syndromes. Each of the four has its strengths and weaknesses. Vertical societies are those whose members tolerate hierarchical relations. Horizontal societies prefer relative equality. Cultures which emphasize horizontal individualism include the social democracies of western Europe, Australia and New Zealand. These cultures allow individuals to pursue their own goals without undue obligations to ingroup members. A shortcoming of horizontal individualism is social isolation, because individuals may end up pursuing their own goals in the absence of major social support for their endeavors. Societies with vertical individualism emphasize inequality and competition, which may lead to high levels of creativity and greater effort. A negative consequence is stress, and, after failure of competition, depression. The US is typically viewed as emphasizing both horizontal and vertical individualism (Ayçiçegi & Harris, in preparation). Societies which emphasize horizontal collectivism foster social support and sociability. A negative consequence is that the energies of group members may be absorbed in social relationships, decreasing productivity. With vertical collectivism, individuals subordinate their own desires to those of group leaders. This allows the group to undertake efforts which require social cohesion and individual self-sacrifice such as monument building. The negative social consequence of vertically collectivistic societies include the risk of authoritarian regimes and ethnic violence, as may occur when group leaders activate ingroup–outgroup animosities.

Advantages and Disadvantages of Individualism and Collectivism at the Level of Individual Persons

During the last 15 years of work on individualism and collectivism researchers have taken an interest in the personality correlates of these cultural syndromes (Ayçiçegi & Harris, in preparation; Triandis, Bontempo, Villareal, Asai, & Lucca, 1988; Triandis & Gelfand, 1998; Triandis, Leung, Villareal, & Clack, 1985; Triandis & Trafimow, 2001; Oyserman et al., 2002; Shafiro, Himelein, & Best, 2003). A large body of empirical research shows individual differences between idiocentrics and

allocentrics: Allocentrics value tradition and conformity, while idiocentrics value hedonism, stimulating experiences and self-direction (Schwartz, 1990; Triandis & Trafimow, 2001).

Idiocentrics pay principal attention to their own internal beliefs, while allocentrics use context more when making attributions (Smith & Bond, 1999). Idiocentrics are self-enhancing, allocentrics are modest (Markus & Kitayama, 1991). Idiocentrics display social loafing more than allocentrics. They work better alone than with ingroup members, and work best when they have a choice in what activities they will undertake (Triandis, 2001).

Harmony is an important value among allocentrics. Allocentrics are more sensitive to social rejection, lower in uniqueness and higher in affiliation than idiocentrics. Allocentric persons in the US obtain lower scores than idiocentrics on measures of anomie, alienation, and loneliness (Triandis et al., 1985). They perceived that they received more social support of better quality, and value cooperation, equality and honesty. Idiocentric persons valued a comfortable life, competition, pleasure and social recognition. Idiocentrics have high self-efficacy. For example, biographies suggest that famous people in Japan are more likely to be idiocentric members of that society (Triandis et al., 1985).

In different situations, people may access either their 'individual self' or their 'relational self' (Triandis & Trafimow, 2001). When the individual is alone, individualist cognitions are more likely. Instructing people to think for 2 minutes about what makes them the same as their family or friends leads to more collectivist responses, while instructions to think about what makes them different from family and friends result in more individualist responses (Trafimow, Triandis, & Goto, 1991). Using a different language or emphasizing cultural backgroud can promote responses that tap allocentric or idiocentric personality attributes (Triandis & Trafimow, 2001).

The Person–Environment Fit

In discussing cultural influences on subjective wellbeing, Triandis (2000) has proposed the concept of 'person–environment fit'. Having a personality which matches the values of the overarching culture should increase subjective wellbeing, while a mismatch will decrease it.

Wachs (2000) has reviewed studies on the fit between the individual and culture. He notes that 'individuals whose characteristics fit well within a given culture context will tend to show better adaptation to this context than individuals with characteristics that run counter to the demands of their culture' (pp. 166–167). A comparison of Anglo-American and Mexican-American school children in the US found that the students with the highest self-esteem were the more competitive Anglo children and the

more cooperative Mexican children (Knight & Kagan, 1982). Personality traits which are viewed as desirable in a culture are also more stable over time than traits that are less desirable (Kerr, Lambert, & Bem, 1996).

Ward and Chang (1997) adopted a 'cultural fit' perspective to understand sojourner adjustment. Examples of a poor fit include sojourning students from collectivist cultures who suffer stress while adjusting to the individualist social demands of North American culture. Schmitz (1994) found that East Germans who moved to West Germany before 1990 adjusted to West Germany if they scored highly on idiocentrism, but did poorly if they scored highly on allocentrism. When the match between personality and culture is poor, people may try to move to another culture that fits them better (Triandis, 2000). In individualist cultures, allocentrics join groups, gangs, communes, and unions, while the idiocentrics in collectivist cultures feel oppressed and want to leave (Triandis & Trafimow, 2001).

In a unique experimental study, Chatman and Barsade (1995) randomly assigned allocentric and idiocentric persons to simulated cultures (collectivist vs. individualist). Both types of persons were uncooperative when assigned to an individualist culture. The allocentrics were very cooperative in the collectivist culture, idiocentrics mildly so.

Our proposal that a 'personality–culture clash' is a risk factor for mental health is consistent with the 'culture fit' proposals of Ward and Chang (1997) and Triandis (2000) and the other authors cited earlier.

Subclinical Variation in Mental Health

Cross-cultural researchers have concentrated on exploring how the incidence and severity of mental illness vary across individualist and collectivist cultures. Much less is known about the range of subclinical variation found in people without overt disorders. The current study investigates the personality–culture clash by surveying college students for symptoms of psychological distress. We administered individualism–collectivism personality scales, and 7 clinical scales measuring features of psychiatric conditions such as antisocial personality disorder, narcissism, depression, and social anxiety (see Materials for a complete list and description of measures). Our battery included psychometrically sound measures such as the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979) and the Personality Diagnostic Questionnaire (PDQ-4; Hyler, 1994). The scales we employed are typically used as screening devices to assist clinicians in conducting diagnostic interviews, as diagnostic aids, to confirm a diagnosis when clinical patients are included in research studies, or to quantify severity of symptoms for patients who have already received a diagnosis.[1]

There are a number of advantages to studying self-report of features associated with psychiatric conditions in a nonclinical sample. While sampling convenience is of course one advantage, a college-student sample minimizes the disadvantages of studying individuals whose symptoms are severe enough to bring them to the attention of the medical system, or who have sought out a diagnosis (Rosen & Tallis, 1995). Patients may have a prior history of hospitalization, prolonged medication use, interrupted schooling, aberrant interactions with family, lowered career aspirations, and the negative effects of being labeled as having a disorder.

As reviewed earlier, the literature on individualism/collectivism and mental health describes relationships holding at the societal level. Individualism/collectivism at the societal level is maintained by different factors than those influencing idiocentrism and allocentrism (Triandis, 2000). Do forces operating at the societal level hold among individual persons? If so, the current literature review makes the following predictions about how idiocentric vs. allocentric personality features will correlate with characteristics of psychiatric conditions.

The view that individualism is a mild form of psychopathy (Hui & Triandis, 1986) predicts that idiocentrics will have higher scores on clinical scales of antisocial personality disorder and possibly also narcissism. These individuals will also have low scores on measures of empathy and social anxiety. No predictions are made about collectivism or other psychiatric disorders.

The 'ills of individualism' perspective of Lane, Lasch, Spence and others predicts that idiocentrics' personality features will be associated with increased psychiatric symptoms, across a broad spectrum of diagnostic categories. The corollary of this is that allocentric persons will have relatively low scores on clinical scales.

According to the 'advantages and disadvantages' perspective, individualist and collectivist orientations are associated with distinct risk factors and protective factors. Idiocentrism will be correlated with increased scores on clinical scales for antisocial personality disorder, narcissism, and impulsivity. Allocentrism is hypothesized to be associated with vulnerability to depression, anxiety and compulsive personality traits, and thus collectivism scores will correlate with increased scores on the relevant scales.

Our own alternative to these predictions from the literature is the personality–cultural clash hypothesis. According to the personality–cultural clash hypothesis, the main vulnerability is to have a mismatch between personality traits and the values of the surrounding culture. We thus predict that idiocentrics will have higher scores on clinical scales when they reside in a collectivist culture. If there is a tendency for allocentrism to correlate with depression and anxiety, and idiocentrism to

correlate with disorders of impulse control, then these patterns will be exaggerated when a personality–culture clash is present.

We chose the cities of Istanbul and Boston as the locations for this cross-cultural project because Turkey and the US are widely believed to differ on the dimension of individualism/collectivism (Oishi, 2000; Phalet & Hagendoorn, 1996), and because of our prior experience with administering clinical and personality measures to students and patients in Istanbul (e.g., Ayçiçegi, Dinn, & Harris, 2003, 2005).

Method

Sample

The American sample consisted of 131 Boston University students and the Turkish sample of 96 Istanbul University students. Students in both groups participated for course credits, and were selected so that age, gender and years of education were similar across groups, and so that males and females within a group had comparable age and educational levels. The mean age of the Boston group was 18.5 years (SD = 1.2, range = 17–25), and the mean age of the Istanbul group was of 19.7 years (SD = 2.0, range = 17–24). The larger proportion of females reflects the gender ratio in the College of Arts and Sciences at Boston University. For the Istanbul group, a similar ratio of males and females were selected. Mean educational level across the two samples was 13.5 years (SD = 1.3), indicating that most students were in their first years of postsecondary education.

Measures

Individualism–Collectivism

Many different measures of individualism and collectivism exist (Oyserman et al., 2002). A standard method is to ask respondents to endorse checklists of items, as in the well-known scale of Triandis et al. (1988). Singelis, Triandis, Bhawuk, and Gelfand (1995) noted that yes/no checklists are susceptible to demand characteristics, and also require respondents to introspect and form theories about their own personality. The alternative method advocated by Singelis and colleagues used the scenarios developed by Triandis, Chen and Chan (1998). The scenarios describe a situation and ask the respondent to choose from one of four options. For example, one scenario asked how the restaurant bill should be divided (leader pays/decides, split equally, etc.). Using an established checklist method to measure individualism–collectivism, an Illinois sample did not differ from a Hong Kong sample, despite widespread agreement that the former is strongly individualist and the latter collectivist

(Singelis et al., 1995). Using the scenarios, the Hong Kong sample made more collectivist choices.

The scenarios were designed to incorporate recent theorizing that individualism and collectivism can be qualified by the dimension of vertical and horizontal social structures (incorporating earlier ideas from Hofstede, 1980). The 17 short scenarios are presented in a multiple-choice format with options that correspond to the four categories of individualism/ collectivism crossed by the horizontal/vertical dimension. For example, a sample question is:

> In your opinion, in an ideal society national budgets will be determined so that:
>
> People can feel unique and self-actualized (Horizontal Individualism).
>
> All people have adequate incomes to meet basic needs (Horizontal Collectivism).
>
> Some people will be rewarded for making brilliant contributions (Vertical Individualism).
>
> There will be maximum stability, law and order (Vertical Collectivism).

The scenarios have been translated into Turkish and were used in a prior study (Ayçiçegi & Harris, in preparation).

Motivation for Selection of Clinical Scales

We administered self-report measures of symptoms of personality disorders, ADHD, depression, obsessive–compulsive symptoms, social anxiety, empathy, and impulsiveness.

The PDQ-4 is a true/false questionnaire that yields subscale scores reflecting DSM-IV diagnostic criteria for personality disorders (Hyler, 1994). These are symptom thresholds which can be used in clinical screening. Ayçiçegi's translation used the back-translation method (Ayçiçegi, Dinn, & Harris, 2004).

The Schizotypal Personality Questionnaire-B (SPQ-B; Raine & Benishay, 1995) is a 22-item, forced-choice questionnaire, with scores ranging from 0 to 22. Items correspond to DSM-IV diagnostic criteria for schizotypal personality disorder and are frequently used by clinicians to evaluate respondents for the presence of schizotypal personality features. The SPQ-B yields three subscale scores reflecting: (1) Cognitive or perceptual distortions (e.g., 'Have you ever had the sense that some person or force is around you, even though you cannot see anyone?'); (2) interpersonal difficulties (e.g., 'Do you feel that you are unable to get close to people?'); and (3) disorganization (e.g., 'I sometimes use words in unusual ways') (Raine and Benishay, 1995, p. 351). The Turkish

translation has been normed and validated (Ayçiçegi, Dinn, & Harris, 2002, 2004).

The Beck Depression Inventory (BDI; Beck et al., 1979; Turkish translation: Hisli, 1988) assesses the severity of depressive symptoms. The scale consists of 20 items reflecting mood, feelings of self-worth, pessimism, social engagement, and vegetative symptoms (lack of sexual activity, difficulties sleeping, and weight loss). This scale has been used previously in cross-cultural research (e.g., Lay et al., 1998).

The Obsessive–Compulsive Inventory (OCI; Foa, Kozak, Salkovskis, Coles, & Amir, 1998) allows measurement of OCD symptom subtypes. The OCI has 7 subscales (42 items in all) which reflect compulsive washing, checking, doubting, ordering, obsessional ideation, hoarding, and mental neutralizing. Participants indicate the frequency of and distress associated with OC symptoms, rated on a 5-point Likert scale (0–4). Thus, each of the 7 subscales yields both a distress score and a frequency score. The Turkish translation has been previously used in our prior OCD research (Ayçiçegi et al., 2004; Ayçiçegi, Harris, & Dinn, 2002).

The Liebowitz Social Anxiety Scale (Liebowitz, 1999) is a 24-item instrument which yields two subscale scores reflecting symptom severity and avoidance behavior. Subjects are instructed to indicate the degree of anxiety they experience during specific social situations. Subjects also indicated how frequently they avoid these social situations. Very low scores on scales of social anxiety are obtained in persons with antisocial personality disorder (Dinn & Harris, 2000).

The Current Symptoms Scale assesses symptoms related to Attention Deficit and Hyperactivity Disorder (ADHD). Developed by Barkley and Murphy (1998), this 18-item self-report screening measure for adult ADHD yields 3 scores reflecting DSM-IV diagnostic criteria for: (1) ADHD, predominantly hyperactive–impulsive type; (2) ADHD, predominantly inattentive type; and (3) ADHD, combined type. The Turkish translation has appeared in Ayçiçegi et al. (2003).

Three subscales of the 17 Impulsiveness Questionnaire (Eysenck, Pearson, Easting, & Allsopp, 1985), measure personality traits which may show interesting cross-cultural variation: Empathy, impulsiveness, and venturesomeness. These three traits have been linked to psychiatric syndromes. Autism and antisocial personality (or psychopathy) can be understood as disorders of empathy, while impulsiveness is a symptom of ADHD, antisocial personality disorder and borderline personality disorder.

The Turkish participants also completed two additional measures: the SCID-II (Sorias et al., 1990) and the Maudsley Obsessional–Compulsive Inventory (MOCI; Hodgson & Rachman, 1977). The first of these concerns personality disorders and thus overlaps with the PDQ-4, while

the second overlaps with the OCI (Foa et al., 1998). We administered these additional measures because our Turkish translations of the PDQ-4 and the OCI were newly done for the current project and thus had not been used in prior research when planning the current study in 2000, although studies have been recently published using these translations (Ayçiçegi et al., 2002, 2004; Ayçiçegi, Dinn, Harris, & Erkmen, 2003).

Existing Turkish-language versions of the Maudsley Obsessional-Compulsive Inventory (Erol & Savasir, 1988), the SCID-II (Sorias et al., 1990) and the Beck Depression Inventory (Hisli, 1988) were administered. The other questionnaires had been previously translated by Ayçiçegi and normed and validated in prior research on Turkish psychiatric patients, students, and community members.

These self-report scales can be seen as measuring subclinical personality characteristics, obsessive–compulsive traits, depressive features, or schizotypal personality characteristics. Many of these scales have been widely used with nonclinical populations, such as the Beck Depression Inventory (BDI) and Schizotypal Personality Questionnaire (SPQ). In such studies, the goal is generally to measure personality features associated with clinical syndromes or to measure markers of various types of psychological distress. For example, Lay et al. (1998) used the BDI to measure depressive features in a student population, and correlated these with familial allocentrism, showing that family connectedness buffered against report of depressive symptoms. Considerable continuity exists between characteristics of students who have subclinical personality disorder features and psychiatric patients who have received a clinical diagnosis (Dinn et al., 2004).

Results

We first present the primary data of interest: Is there an association between individualism/collectivism and report of clinical symptoms, and does this association differ between an individualist culture (the US) and a collectivist culture (Turkey)? To address this issue, we present both correlational data and mean scores. We then provide symptom scores for each cultural group, and scores for the individualism–collectivism scenarios.

For each participant we obtained six scores from the individualism–collectivism scenarios: Four scores for HI, HC, VI, and VC (corresponding to horizontal individualism, horizontal collectivism, vertical individualism and vertical collectivism), and a total individualism score (combining HI, VI) and a total collectivism score (combining HC, VC). For example, HI scores ranged from 0 to 17, indicating the number of scenarios on which the participants chose the HI choice, while total individualism scores could range from 0 to 32. For each cultural group, we

correlated participants' HI, HC (etc.) scores with participants' scores on the clinical scales. For clinical scales, a high value indicates a high number of symptoms. Thus, negative correlations mean that individualism may protect against report of subclinical symptoms.

Correlational Analysis

American Sample

For ease of scanning our tables, the highest scores appear in bold. For the American sample, participants' individualism scores correlated negatively with the dependent personality subscale of the PDQ-4, the Obsessive–Compulsive Inventory (including 5 subscales, see Table 1), Liebowitz Social Anxiety Scale, Beck Depression Inventory, and with the inattentive subscale of the Current Symptoms Scale, a measure of ADHD. The negative correlation means that idiocentric personality was associated with lower symptom report. Collectivism scores correlated positively with these same clinical scales, meaning that allocentrism as a personality dimension co-occurred with features of psychiatric disorders. In particular, collectivism scores were associated with dependent personality and social anxiety. Collectivism scores did correlate with one personality trait that can be seen as indicative of good mental health: Empathy. Individualism was associated with venturesomeness, which is similar to core features of individualism (risk taking and having high self-direction).

When individualism–collectivism scores were subcategorized according to horizontal and vertical dimensions, some subtleties emerged. While both types of collectivism were associated with dependent and avoidant personality features, VC was also associated with report of paranoid traits, and with attentional difficulties associated with ADHD (and very weakly with hyperactive characteristics; see Table 1). Horizontal collectivism was associated with depressive features, but horizontal individualism was inversely associated with depression scores. Indeed, our findings suggest that, at least for American college students, HI is the healthiest personality style.

The overall picture is that, in American culture, individualism is associated with low self-report of psychological distress. This refutes the proposal that Lasch's (1991) and Lane's (2000) 'ills of individualism' view can be extended to the level of individual persons. Instead, findings are consistent with Waterman's (1984) proposal that at least some forms of individualism are consistent with psychological health.

Turkish Sample

A startlingly different pattern of correlations was observed in the Turkish data. Individualism, and horizontal individualism in particular, was the

TABLE 1
Correlations between individualism and collectivism and psychiatric symptoms for American sample ($N = 129$) (only significant results shown)

	Total Individualism	*Total Collectivism*	*VI*	*HI*	*HC*	*VC*
Personality Diagnostic Questionnaire (PDQ)						
Paranoid			.19*			.18*
Schizotypal			–.18*	.20*		
Narcissistic			.24**			
Avoidant	–.23**	.26**			.18*	.18*
Dependent	–.35**	.36**		–.31**	.28**	.20*
Schizoid					–.21**	
Antisocial†	.12	–.12	.03	.07	–.08	.07
Obsessive–Compulsive Inventory (OCI)						
Checking Distress	–.21**	.22**			.19*	
Hoarding Distress	–.27**	.26**			.19*	
Mental Neutralizing Distress	–.21**	.22**				
Ordering Distress						.19*
Mental Neutralizing Frequency	–.24**	.25**			.18*	
Total Distress	–.20*	.20*				
Total Frequency	–.19*	.20*				
Social Anxiety (Liebowitz)	–.31**	.31**		–.18*	.19*	.24**
Schizotypal Questionnaire (SPQ)						
Schizotypal-Positive				–.19*		.17*
Attention Deficit Disorder (CSS)						
Combined Type	–.18*	.17*				.28**
Inattentive Type	–.26**	.25**	–.19*			.32**
Hyperactive Type						.19*
Depression (Beck)	–.28**	.27**		–.23**	.20*	
Personality Scale (17 Impulsiveness Questionnaire)						
Venturesome	.33**	–.33**		.28**	–.23**	–.21**
Empathy	–.32**	.34**		–.23**	.34**	

Notes. ** = .01; * < .05; † = Not significant, but listed for theoretical interest. *Not significant: Personality Diagnostic Questionnare (PDQ-4)*: Histrionic personality, antisocial personality, borderline personality, OC personality. *Obsessive–Compulsive Inventory*: Compulsive washing distress, doubting distress, obsessional ideation distress and mental neutralizing distress, compulsive washing frequency, checking frequency, doubting frequency, ordering frequency, obsessional ideation and hoarding frequency. *Schizotypal Personality Questionnaire-B (SPQ-B)*: Schizotypal negative type and disorganization type. *Personality Scale (17 Impulsiveness Questionnaire)*: Impulsivity.

least healthy personality style. Horizontal individualism correlated with report of paranoid and narcissistic features, with the positive subscale of the schizotypal personality disorders subscale (indicating magical thinking, unusual perceptual experiences and ideas of reference), impulsivity, antisocial personality (as measured by the SCID-II) and borderline personality features (see Table 2). In contrast, collectivism generally, and vertical collectivism in particular, was associated with low scores on many of these same clinical scales.

These broad correlational findings are consistent with the personality–culture clash hypothesis, and inconsistent with alternative predictions outlined above.

TABLE 2
Correlations between individualism and collectivism and psychiatric symptoms for Turkish sample ($N = 96$) (only significant results shown)

	Total Individualism	*Total Collectivism*	*VI*	*HI*	*HC*	*VC*
Personality Diagnostic Questionnaire (PDQ)						
Paranoid					–.28**	
Schizotypal				.28**		
Narcissistic	.25**	–.23*				
Antisocial	.29**	–.32**		.34**		–.27**
Borderline	.23*	–.22*				
Obsessive–Compulsive Scale (MOCI)						–.31**
Schizotypal Questionnaire (SPQ)						
Schizotypal-Positive		–.22*		.29**		
Schizotypal-Disorganization		–.21*				–.25**
Personality Scale (17 Impulsiveness Questionnaire)						
Impulsivity	.21*	–.22*		.25**		
Personality Disorder Scale (SCID-II)						
Paranoid				.21*		
Schizotypal				.25**		–.28**
Narcissistic	.20*		.23*			
Antisocial						–.25**
Borderline	.23*	–.23*		.23*		–.25**
Schizoid	.26**	–.27**		.23*	–.22*	

Notes. ** = .01; * < .05. Scales which were not significant were the following subscales of the Personality Diagnostic Questionnare: Schizoid Personality, Histrionic Personality, OC Personality, Avoidant Personality, and Dependent Personality; the Obsessive–Compulsive Inventory; the Liebowitz Social Anxiety, negative symptoms subscale of the Schizotypal Questionnaire; Attention Deficit Disorder (CSS); Depression (BDI), the Venturesome and Empathy subscales of 17 Imulsiveness Questionnaire, and the Histrionic Personality, OC Personality, Dependent Personality of the Personality Disorder Scale (SCID-II).

Analysis by Allocentrism and Idiocentrism

As an exploratory measure, we used the individualism–collectivism scenarios to classify students according to whether their overall tendency was to make individualist or collectivist responses. Here we used the total individualism and total collectivism scores (i.e., collapsing over the vertical/horizontal dimension). One standard deviation above the mean (for each culture) was the cutoff for categorizing students as largely idiocentric or largely allocentric. Students who had mid-range scores on both collectivism and individualism were the numerically largest group, and were thus placed in a third category labeled 'adaptable'.

Table 3 shows the American data. The preponderance of high clinical scores occurred for the allocentric individuals. Across the 15 clinical scales (thus excluding the 17 Impulsiveness Questionnaire) for which a statistically significant difference occurred, on 13 of these scales allocentrics had the highest score. This repeats the finding in the correlational data, where collectivist scores were correlated with higher scores on clinical tests. Interestingly, the group with the lowest scores was not the idiocentric group, but the adaptable group. The adaptable group reported the fewest symptoms of any of the three groups on all but three scales.

These results suggest that in American culture, having a personality which is a blend of individualism and collectivism is a marker of mental health. However, extreme collectivism is the strongest marker of poor mental health. High individualism is associated with schizoid and narcissistic personality features (see top panel in Table 3). This analysis supports the view that individualism and collectivism have advantages and disadvantages. High individualism was associated with narcissism, consistent with Lasch (1991), although it was not associated with antisocial personality features. The association with schizoid features indicates withdrawal from others, and is thus broadly consistent with the social disintegration hypothesis (Paris, 1996).

Idiocentrics had the lowest report of dependent personality, social anxiety and depression. These three scales plausibly co-occur with lack of attachment to other people. Being very independent likely co-occurs with having little social anxiety because one cares little for others (antisocial personality disorder is negatively correlated with social anxiety; Dinn & Harris, 2000). Extreme idiocentrics may have little depression because of inflated self-esteem. These findings about low scores on clinical scales are a reminder that a low score does not necessarily mean optimal mental health. Depending on the scale, a very low score on a clinical scale may represent an extreme response, and thus may be a marker of a non-optimal personality style.

The same analysis on Turks was also performed (i.e., dividing individual participants into allocentrics, idiocentrics, and adaptables). As shown

TABLE 3
Mean scores and Standard Deviation for three groups of Americans

	Collective *n = 30*		*Individual* *n = 22*		*Adaptable* *n = 77*		*F*	*p-value*
Personality Diagnostic Questionnaire (PDQ)								
Schizoid Personality	1.1	(1.2)*	**1.6**	**(1.6)**	0.8	(1.2)*	4.1	.02
Paranoid Personality	**3.5**	**(1.9)**	3.1	(2.0)	2.6	(1.7)*	2.9	.06
Narcissistic Personality	3.5	(1.6)	**4.0**	**(1.5)**	2.6	(1.8)*	7.1	< .01
Avoidant Personality	**3.3**	**(2.2)**	2.0	(1.6)*	2.2	(1.8)*	4.6	.01
Dependent Personality	2.3	(2.1)	0.9	(1.1)*	1.5	(1.5)	4.8	< .01
Include antisocial??								
TOTAL	**34.1**	**(13.9)**	31.1	(9.4)	26.4	(11.6)*	5.0	< .01
Obsessive–Compulsive Scale (OCI)								
Checking Distress	**8.8**	**(7.2)**	5.9	(4.2)	5.3	(4.5)*	4.7	.01
Hoarding Distress	**4.0**	**(3.0)**	2.3	(2.1)	2.6	(2.3)*	4.2	.01
Mental Neutralizing Distress	**5.1**	**(4.6)**	2.8	(2.2)*	3.0	(3.0)*	5.0	< .01
Checking Frequency	**11.7**	**(7.5)**	8.6	(5.1)	7.8	(4.7)*	5.4	< .01
Mental Neutralizing Frequency	**7.2**	**(5.1)**	4.0	(2.9)	4.7	(3.3)*	5.8	< .01
Obsession Frequency	**9.1**	**(6.5)**	5.6	(5.0)	6.2	(5.1)*	3.6	.03
Total Distress	**43.4**	**(30.8)**	30.0	(18.6)*	32.1	(22.7)*	2.8	.06
Total Frequency	**56.2**	**(32.4)**	42.5	(22.0)	42.2	(20.5)*	3.9	.02
Schizotypal Questionnaire (SPQ)								
Disorganization	**9.9**	**(5.2)**	9.6	(5.3)	7.6	(4.1)	3.7	.03
Negative	**3.4**	**(2.3)**	3.0	(2.4)	2.2	(2.0)*	3.9	.02

TABLE 3
Continued

	Collective *n = 30*		*Individual* *n = 22*		*Adaptable* *n = 77*		*F*	*p-value*
Personality Scale (17 Impulsiveness Questionnaire)								
Venturesome	7.3	(3.6)*	**10.0**	**(3.3)**	9.4	(3.4)*	5.1	< .01
Empathy	**13.9**	**(3.1)**	11.2	(4.2)*	**13.9**	**(3.8)***	4.6	.01
Attention Deficit Disorder (CSS)								
Inattentive Type	**1.4**	**(1.9)***	0.5	(1.0)*	0.7	(1.1)*	4.3	.02
Social Anxiety (Liebowitz)	**42.4**	**(21.1)***	27.5	(15.5)*	33.9	(19.2)	4.1	.02
Depression (Beck)	**11.0**	**(8.7)***	4.9	(3.5)*	7.6	(7.5)	4.6	.01

Notes. The highest score appears in bold. * symbol indicates which item was statistically significant when compared to the highest score. Table only lists those subscales, from all tested, that resulted in a statistically significant (or near signiciant, $p < .07$) difference between cultural groups.

TABLE 4
Mean scores and Standard Deviation for Turks divided into three groups

	Collective n = 18		*Individual n = 24*		*Adaptable n = 54*		*F*	*p-value*
Antisocial personality	0.9	(0.8)*	**1.8**	**(1.6)**	1.2	(1.3)	2.8	.07
Schizoid	0.6	(0.6)*	**1.3**	**(1.1)**	0.8	(0.9)	4.4	.02

Notes. 'Antisocial personality' is the subscale from the Personality Diagnostic Questionnaire (PDQ); 'Schizoid' is a subscale from the Personality Disorder Scale (SCID-II). The highest score appears in bold. * symbol indicates which item was statistically significant when compared to the highest score. Table only lists those subscales, from all tested, that resulted in a statistically significant (or near significant, $p < .07$) difference between cultural groups.

in Table 4, few significant differences emerged. However, when differences were present, a complimentary picture to that of the American data emerged. Here, the psychologically most healthy group was not the adaptable group, but actually the group that was least healthy in the American sample: The allocentrics. The allocentrics had the fewest antisocial personality symptoms and the least schizoid symptoms.

Differences in Individualism–Collectivism Scores between Turks and Americans

Table 5 shows mean scores for the HI, HC, VI and VC choices. Turks were more collectivistic than Americans in that they selected vertical collectivist (VC) choices more frequently than did Americans. Greater choice of VC by members of collectivist cultures has been noted in other studies (Triandis et al., 1998).The percentage choice across the two cultures is highly similar to that found in Ayçiçegi and Harris (in preparation). Americans made slightly more HC choices than Turks, while Turks made more VC choices. Horizontal collectivism may be a proxy for egalitarian connections with peers, which is an important value in American student

TABLE 5
Individualism and collectivism scores for Americans and Turks

	Americans	*Turks*	*t(223)*	*p*
HI	7.6	8.0	1.5	.11
HC	**4.9**	3.6	5.9	.001
VI	3.1	3.3	0.7	.49
VC	1.3	**2.1**	4.6	.001

Note. The higher score in a statistically significant comparison is printed in bold.

culture. In contrast, vertical collectivism likely remains a marker of Turks' traditional concern with duty and obligation to one's ingroup.

Discussion

The American and Turkish samples yielded startlingly different patterns of correlations between individualism–collectivism scores and clinical scales. Idiocentrism had the highest number of significant correlations with clinical scales in the Turkish sample, but allocentrism had the highest number of significant correlations in the American sample. In short, Turkish idiocentrics and American allocentrics had the highest scores on clinical tests. These findings support the personality–cultural clash hypothesis, which states that a mismatch between personality and societal values is a risk factor for nonoptimal outcomes, which could include poor mental health and vulnerability to psychiatric disorders.

Given the heuristic and exploratory nature of the current study, many discussion issues can be raised. Does the present study shed light on the position that individualism, in its extreme form, is associated with disorders of impulse control? Are the current data consistent with the view that individualism and collectivism have distinct advantages and disadvantages? The current data are correlational: What can be concluded about the direction of the causal arrow? Can we claim that Turkey is a collectivist culture, given Turks' high individualism scores (Table 5)? Are there other dimensions on which Turkey and the US differ which could explain the observed cross-cultural differences?

We discuss these later, but mention here some important limitations of the current study. We need to be careful about drawing conclusions about mental health, given that our respondents were college students and not psychiatric patients. University students are a special, privileged group who may be less affected by cultural pressures, and tend not to include individuals with severe psychopathology. Also, the Turkish group may be a more elite group, given that a smaller proportion of the population attends university in Turkey. Nevertheless, there is no obvious reason why being a more elite group would lead to the observed correlations. Given that our dependent variables were self-report rather than clinical diagnoses, our clinical tests should be regarded as measuring personality dimensions. However, we argue that the scales measure subclinical levels of disorders and personality dimensions which may place individuals at risk for psychiatric disorders.

Is Individualism Associated with a High Rate of Psychiatric Symptoms?

The hypothesis that individualism is associated with disorders of impulse control (as advocated at the societal level by Cooke, 1996; Horgan, 1975; Paris, 1996) was supported in the Turkish sample but not the American sample. Percentage of idiocentric choices was correlated with scores on the antisocial and borderline personality subscales of the PDQ-4, on the 17 Impulsiveness Questionnaire, and the borderline subscale on the SCID II (Table 2). Idiocentrics in the American sample had high narcissism scores, confirming the proposal that extreme individualism is associated with exaggerated self-concern (Lasch, 1991). However, idiocentrism was associated with different intercorrelation patterns in the U.S. and Turkey samples. Idiocentrism was correlated with antisocial and borderline personality scales (but not narcissism) in the Turkish sample. In the U.S. sample, idiocentrism was correlated with narcissism, but not with antisocial and borderline personality.

These differing patterns support the personality–culture clash hypothesis: Idiocentric choices on the individualism–collectivism scenarios, and idiocentrism as a personality trait, may be more anomalous in Turkey than in America, signaling a more socially deviant personality.

Persons with individualist personality traits did not have more anxiety or depression in either sample, thus refuting the general 'ills of individualism' position (Lane, 2000; Lasch, 1991; Sampson, 1977; Spence, 1985). Indeed, for the U.S. sample, endorsing individualist opinions was correlated with having low anxiety, low depression, and low mental distress.

Advantages and Disadvantages of Individualism vs. Collectivism

This view includes the idea that idiocentrism is a risk factor for disorders of impulse control, but adds the complementary idea that allocentrism has its own disadvantages. Just as the extreme of individualism is excessive self-regard, the extreme of collectivism is excessive concern (and thus anxiety) over one's relations with others. The American data clearly supported this. Allocentrism was a less psychologically healthy personality style in the US, but it did not correlate with narcissism or antisocial personality disorder. The personality scales which correlated with allocentrism included those that can be seen as extreme forms of a highly relational personality. Scales that make the most sense in this regard are also the ones with the strongest correlations: dependent personality disorder (r = .36), social anxiety disorder (r = .31), and, on the side of a positive personality dimension, empathy (r = .31). Low venturesomeness (r = –.33) is also consistent with

the view that endorsing a high number of collectivistic traits co-occurs with a threat-sensitive personality.

In contrast, in the Turkish sample, allocentrism was not a risk factor for social anxiety and dependency. Instead, allocentrism was correlated with low scores on all clinical tests and thus can be seen as the healthiest personality style (in Turkey). Individualism and collectivism as personality traits may have distinct advantages and disadvantages, but this is modulated by culture.

Direction of Causality

The viewpoints reviewed in the initial section of this article are causal statements: A society's individualist or collectivist values impacts on an individual's mental health. Of course, no theorists claim that values act alone. Instead they facilitate, promote, or influence mental health and personality. What factors mediate this influence? That is, why is an individualist or collectivist orientation which clashes with a culture's values a risk factor for having a psychiatric syndrome?

One possibility is that having a personality which is discrepant from societal values is a stressor. Children who are competitive, self-reliant and aloof from others may find their personalities tolerated or even rewarded in an individualist society, thus fostering healthy development of an adult persona. In a collectivist society, the competitive, self-reliant, aloof child may fail to develop culturally appropriate relations with others, leading to rejection by peers and harsh treatment by adults. Peer rejection is well known as a risk factor for the development of psychiatric problems (e.g., see Asher & Coie, 1990).

In considering child rearing, Rosenthal and Bornholt (1988) note that children with allocentric traits learn to be good ingroup members but may or may not learn also to be self-reliant, independent, achieving. Children with idiocentric traits may learn to be independent and self-reliant, but they may not learn to be good team players. Children plausibly learn the dominant values of the culture first and are influenced by them more strongly than they are by less dominant patterns of behavior.

Personal sacrifice brings a sense of satisfaction for individuals who live in collectivist cultures (Triandis et al., 1988). Allocentric persons in collectivist cultures feel positive about accepting ingroup norms. In contrast, idiocentric persons in collectivist cultures feel ambivalent and even bitter about acceptance of ingroup norms. They wonder if this or that norm is necessary, or if they should comply with it. Consequently, where allocentric persons in collectivist cultures may experience consistency among the behavioral, affective, and cognitive elements of their social behavior, idiocentrics may experience discrepancies. They may comply with societal

norms, while questioning their validity. This feeling of discrepancy may be a stressor which detracts from psychological health. These ideas are consistent with studies of sojourner adjustment (Schmitz, 1994; Ward & Chang, 1997).

Note that the causal arrow may run in the other direction. Persons with a healthy personality may be those who are most equipped, during socialization and development, to internalize cultural values. That is, being psychologically healthy allows one to hone in on socially validated personality traits, causing one to be an allocentric in a collectivist society, or an idiocentric in an individualist culture. We suggest that both causal directions may be operative.

There is some evidence that individualist vs. collectivist values influence life satisfaction by influencing personality. Applying structural equation modeling to correlational data from Asian Americans and European Americans, Benet-Martinez and Karakitapoglu-Aygun (2003) found that collectivist vs. individualist dispositions influenced the expression of basic personality dispositions, and these influenced subjective wellbeing. Having individualistic values correlated positively with openness and extraversion, and negatively with neuroticism. These personality traits predicted self-esteem and satisfaction with friends, which then influenced life satisfaction. In contrast, persons with collectivist dispositions had high life satisfaction if they had family satisfaction.

Is Turkey a Collectivist Society?

Cross-cultural researchers continue to characterize Turkey as a collectivist country (Kagitçibasi, 1982, 1996; Kusdil & Kagitçibasi, 2000; Oishi, 2000; Oyserman et al., 2002; Phalet & Hagendoorn, 1996). Turkey is classified with developing regions such as China and Bulgaria on dimensions of political and personal freedom (Inglehart, Basenez, & Moreno, 1998). In both the current study and in Ayçiçegi and Harris (in preparation), Turks had higher vertical collectivism (VC) scores than did Americans, indicating that Turks continue to value obligations to ingroup members. Rural Turks revealed higher collectivism and lower individualism scores than urban Turks (Ayçiçegi & Harris, in preparation).

Nonetheless, Turks and Americans had similar individualism scores both in the current study and in prior work (Ayçiçegi & Harris, in preparation). We hypothesize that urban, educated Turks may reveal western attitudes when responding to a personality scale but that they have still grown to maturity in a country which houses a reservoir of traditional values. Everyday anecdotes about Turkish values and socialization suggest that Turkey is more collectivist than the US. For example, Turkish middle-class parents do not want their teenage children to take after-school jobs.

In the US, even wealthy parents see this as appropriate training for self-reliance and competition. In Turkey, parents hope their children will live at home until marriage, while in the US, living at home can be seen as an alarming sign of dependence. We speculated that the particular brand of collectivism that is most important in Turkey is familialism, the tendency to have a high sense of duty and obligation, and feelings of strong connection, to family members (Gaines et al., 1997; Lay et al., 1998). This hypothesis is currently being tested in a separate study. The 17 scenarios by Triandis and colleagues (1998) may not be helpful for identifying differences in collectivism between the US and Turkey, but are nevertheless a satisfactory means for categorizing individuals as allocentric or idiocentric. We thus feel it is legitimate to conclude that Turkish culture is more collectivistic than U.S. culture.

Alternative Explanations

Is the personality–culture clash the most parsimonious account, or are there other differences between Turkey and the US which could explain the cross-cultural differences obtained here? In the World Values Survey (Inglehart et al., 1998), and on measures of wealth and economic and personal freedom, Turkey is positioned near the opposite end from the US on national rankings of economic and personal freedom. It also has lower levels of subjective well-being than the US (Veenhoven, 2000). There are thus several dimensions on which the US and Turkey differ.

Cultural differences in wealth, economic opportunities and personal freedom are not plausible rivals to the personality–culture clash hypothesis. Economic and personal freedoms allow people to depend less on alliances with family and ingroup, thus facilitating self-reliance and competition. This allows self-reliance and competition to be more psychologically healthy than dependence. Idiocentrism is thus an orientation which works in the US. It is less helpful in a culture where dependence on the ingroup compensates for low economic resources, and affirmation by family means that exercising personal freedom is less rewarding. According to this view, economic and personal freedom are societal forces which maintain a collectivist or individualist orientation. They do not substitute as explanatory variables for individualism/collectivism, but instead explain why cultures differently value individualism and collectivism.

Members of individualist cultures have a self-enhancing bias (e.g., individuals report they have above-average skills and knowledge) compared to members of collectivist cultures (Markus & Kitayama, 1991). Idiocentrics in the US may have a greater self-enhancing bias than allocentrics in the US, meaning that idiocentrics would promote a favorable self-image when responding to clinical scales, leading to low scores and greater apparent

psychological health. Allocentrics in the US are plausibly more modest and more self-critical. They would thus have higher scores on clinical scales. Could this be why the percentage of allocentric choices on the 17 scenarios was correlated with higher clinical scores?

The data in Table 2 directly refute this. When the individualism–collectivism scale was analyzed according to whether participants were extreme idiocentrics (scoring one standard deviation above the mean in their individualism choices), idiocentrics did not have uniformly low clinical scores. Indeed, if 'looking good' was a motive, they were unsuccessful: Idiocentrics had the highest narcissism score and the lowest empathy score. Instead, those participants with a blend of individualist and collectivist choices on the scenarios (the group labeled 'adaptables') had the lowest clinical scores. Nevertheless, it is worth bearing in mind that idiocentrics may have underreported symptoms compared to allocentrics.

Conclusion

Contrary to authors who associate individualism with antisocial personality and disorders of impulse control, idiocentrics reported fewer symptoms characteristic of psychiatric disorders than did allocentrics. However, this was only found in the U.S. sample, where an individualist orientation is normative. In the Turkish sample, where collectivism is more valued, the opposite pattern was found. Allocentrism was the healthy personality, and idiocentrism appeared a risk factor for psychiatric disorders. This pattern supports the personality–culture clash hypothesis.

Correlations within the Turkish and the American data indicate some support for the view we labeled the 'advantages and disadvantages of individualism–collectivism'. This view proposed that being allocentric in an individualist culture has advantages and disadvantages associated with a highly relational style. A personality advantage is having high empathy, while the disadvantages derive from placing a high value on others' opinions (social anxiety) and interpersonal neediness (dependent personality disorder).

Idiocentrism in Turkey has the disadvantages of individualism noted by Lasch (1991), as it is correlated with narcissism. In the US, it has the advantages of low anxiety and low depression, thus plausibly fitting the advantage of seeking self-actualization, noted by Waterman (1984). The advantages of a highly relational style (high empathy) reveal themselves regardless of the culture. That is, allocentrism was correlated with empathy in both the American and the Turkish sample.

Similar to proposals by Triandis (2000), Triandis & Trafimow (2001), Wachs (2000), and Ward and Chang (1997), the current work extends the concept of a 'goodness of fit' (Wachs, 2000) to the realm of culture: A poor

fit between personality and cultural demands is a risk factor for poor psychological health.

The personality–culture clash hypothesis extends the concept of 'goodness of fit', from developmental psychology (Chess & Thomas, 1999; Rutter & Rutter, 1992) to the realm of culture. The goodness of fit hypothesis originated with research on temperament. Which temperament was the 'best' (that is, was associated with healthy development and a favorable long-term outcome) depended on parental expectations that their infants would rapidly acquire the ability to sleep through the night, would be intrigued with novelty or cautious of the unknown, and so on (Chess & Thomas, 1999). This research developed into the theoretical statement that optimal development occurs when children's biological characteristics are consistent with demands placed on them. The goodness of fit hypothesis remains one of the main conceptual models for understanding the interaction of nature and nurture in development (Rutter & Rutter, 1992).

Does this work support cultural universalism or relativism (Tanaka-Matsumi & Draguns, 1997)? According to the universal approach, culture masks underlying human universals. According to relativism, culture exerts a pervasive effect. The current findings support both relativism and universalism. The support for relativism is that whether an idiocentric or an allocentric personality profile correlates positively or negatively with psychiatric symptoms depends on the culture. On the other hand, the data support the fact that a mismatch between personality and cultural values is a risk factor for poor mental health.

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Note

1. We have used Turkish translations of most of these clinical scales previously in Turkey. We have studied OCD patients in Istanbul (Ayçiçegi, Dinn, Harris, & Erkmen, 2003), and patterns of comorbidity in clinical patients (Ayçiçegi, Dinn, & Harris, 2002, 2004). We have also used the clinical scales with Turkish university students (Ayçiçegi et al., 2003, 2005).

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