

January 01, 2008

## Assessing worldview orientation in people of northern rural Maine

Stephanie Helena Poplock  
*Northeastern University*

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ASSESSING WORLDVIEW ORIENTATION IN PEOPLE OF NORTHERN  
RURAL MAINE

A dissertation presented

by

Stephanie Helena Poplock, M.S.W.

Submitted to

The Department of Counseling and Applied Educational Psychology

In partial fulfillment of the requirements for the degree of

Doctor of Philosophy

In the field of

Counseling Psychology

Northeastern University

Boston, Massachusetts

January 2008

NORTHEASTERN UNIVERSITY  
BOUVE COLLEGE OF HEALTH SCIENCES

Graduate School

Doctoral Dissertation Approval Form

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Maine

Author: Stephanie Helena Poplock

Department: Counseling and Applied Educational Psychology

Approved for Thesis Requirements of the Doctor of Philosophy Degree

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ABSTRACT

Assessing Worldview Orientation in People of Northern Rural Maine

Stephanie Helena Poplock, M.S.W.

Northeastern University

Boston, Massachusetts

January 2008

## ABSTRACT

The purpose of this study was to assess the prevalence of individualistic and collectivist influences within a rural sample population in northern Maine. There is not a significant amount of research on the mental health needs of rural populations in the United States. Moreover, no current studies have assessed worldview variables in relation to rural American populations. Worldview variables may be significant factors in the way that people understand who they are and who others are. In addition, worldview may connect to behaviors that may ultimately influence mental health.

The values of specific interest in this research were individualism (a self-orientation with focus on the individual) and collectivism (a self-orientation with focus on relationships with others). Individuals tend to have a prevalence of one orientation over another, even while having tendencies towards both.

A total of 114 Maine residents responded to a survey, obtained through solicitation of various means in rural communities. The survey consisted of: 1) assessing demographic information; 2) two measures examining worldview variables of individualism and collectivism.

Of the total number of respondents, 88 adults met all selection criteria in order to be included in the final sample. Results indicated that this sample reported lower levels of idiocentrism than normative comparisons, and no statistically significant findings involving allocentrism. No significant correlation was found among variables of egocentrism (individualistic indicator) or sociocentrism (collectivistic indicator). Among demographic variables, there were no overriding patterns found

with regard to worldview orientation, although certain variables did hold stronger relationships with individualism and collectivism. The findings of this study and its implications for the field of psychology are discussed through an ecological lens.

## DEDICATION

To my clients in rural community mental health, you inspire me everyday to work with passion and commitment.

## ACKNOWLEDGEMENTS

I would like to thank the following people for their guidance, support, and assistance throughout the process of creating this research project.

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but you are also in many ways friend and family to me. I learn so much from you; your wisdom as a person and a professional is a gift. I embrace your honesty and your ability to be genuine.

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## Chapter I

### *Introduction*

#### *Background of the Problem*

In the rural areas of the United States, there resides a large group of diverse people. This demographic group has both unique as well as universal mental health needs. However, there is not a significant amount of research on the mental health needs of this population. In fact, there is an acknowledged paucity in research and literature of this topic (Barbopoulos & Clark, 2003; Benson, 2003; Evans, 2003; Findlay & Sheehan, 2004; Rokke, & Klenow, 1998; Muehrer, 1997; Spoth, 1997; Murray & Keller, 1991; Wagenfeld, 1988; Kirchner, 1981). Consequently, there is a clear need to expand our understanding of this population, in order to better serve their mental health needs.

#### *Statement of the Problem*

In examining psychological interventions with rural communities, several important questions may arise. First, are rural communities different from urban ones, and, if so, why and how? And next, what are the implications of any differences between these two groups for the types of interventions effective in rural areas (Murray & Keller, 1991; Barbopoulos & Clark, 2003)? These broad questions were addressed on a preliminary scale in this research study involving a rural adult population in northern Maine.

The relative inattention to rural psychology has led to a mental health crisis for a significant portion of the United States. For both mental health researchers and clinicians, it is important to think beyond the individual unit in psychology. That is why an ecological exploration of the rural American will be most useful in working towards the purpose of targeting effective preventive as well as post- intervention initiatives in mental health practice and policy. This research project was thus an

opportunity to examine rural populations ecologically at the individual level.

There are many differences between rural and urban individuals and many possible factors to examine (such as some listed above) among these groups. However, this research focused on the self-orientations of idiocentrism and allocentrism. Before explaining the rationale for this focus, a brief definition of these two concepts is necessary. Idiocentrism is an orientation that a person holds toward the world that centers more predominantly on seeing the self as autonomous and self-reliant. Allocentrism is an orientation that focuses more upon the self in the context of his/her roles in groups and interpersonal relationships.

Idiocentrism and allocentrism are important constructs because, in the practice of psychology, it is necessary to consider the worldview of the individual with whom one is working. Research indicates that the way that people understand who they are, who others are, and their larger worldview all has a strong connection to the way they behave (Rosselo & Bernal, 1999; Sue et al, 1991).

With regard to worldview, it has been suggested by some (Human & Wasem, 1991) that rural communities, similar to certain ethnocultural groups, tend to be more allocentric than urban communities. There has been a consistent theme discussed in research literature suggesting interdependence, cohesion, and community problem-solving abilities among rural individuals (Barbopoulos & Clark, 2003; Benson, 2003; Evans, 2003; Murray & Keller, 1991; Human & Wasem, 1991). It is unclear how solidly based this assumption is. Still, it could be suggested that rural individuals are more oriented in a group rather than individual direction. For example, generally, individuals in rural areas tend to identify more strongly to family, church and community (Bjorklund & Pippard, 1999). There is also the idea of rural communities being “high context cultures,” social organizations with heavy interpersonal reliance, natural supports and loyalty to larger communities (St. Lawrence & Ndiaye, 1997).

Additionally, it may be, as has been suggested by Bjorklund & Pippard (1999), that rural individuals with mental illness might then find more acceptance in the community, leading to the use of more informal mental health supports, such as family or religious leaders.

Conversely, rural individuals may instead be more prevalently idiocentric. Geographic social isolation in rural areas might result in individuals who are struggling, feeling stigmatized, as if no one else shares their plight. Because of the geographic qualities of rural areas, there is a culture of self-reliance, with scarce economic and social resources forcing people to meet their own needs; this extends beyond individuals to communities as a whole (Murray & Keller, 1991).

This research sought to provide an additional contribution to existing research literature on rural populations in the United States, so that mental health care in such populations could be more efficiently tailored to the local needs. Research in this area found no current literature that indicated whether rural individuals are more allocentric or idiocentric. Given the importance of examining worldview as one possible variable in selecting treatment interventions for mental illness, it appeared beneficial to establish whether indeed there were tendencies among rural individuals to be of one orientation over the other.

#### *Definition of "Rural" and "Urban"*

The following definitions do not necessarily capture the complexity of these terms. Often, studies looking at rural populations use the criteria of population, at the exclusion of using other quantitative or qualitative definitions. While it is important to have a clear cut-off in any piece of research, at the same time, the definition of rural is somewhat arbitrary; rural America is a diverse and complex set of areas, and the people within them are not easily summed up.

According to the U.S. Bureau of the Census (2000), rural areas are generally

defined as open country or small settlements including villages, towns, or cities of less than 2,500 members, or areas with population density of less than 500 people per square mile, which exist outside the suburbs of metropolitan cities.

#### *Demographic Characteristics of Rural America*

Rural American towns, villages and farms comprise 2,052 counties, 75% of all United States land, and between 17% and 25% of the American population, based on 2003 federal definitions of nonmetropolitan counties; thus there are approximately 60 million people who live in rural or frontier areas (Economic Research Service, 2003).

For these people, rates of mental illness and substance abuse are equal to or greater than rates in urban areas. One out of five rural individuals will have a mental health problem sometime in his or her life, and many people in rural areas do not seek treatment until they are at the point of crisis (Barbopoulos & Clark, 2003; Fox, Blank, Rovnyak, & Barnett, 2001; Findlay & Sheehan, 2004; Sears, Jr., Danda & Evans, 1999; Chimonides & Frank, 1998; Rokke & Klenow, 1998; Badger, Ackerson, Buttell, & Rand, 1997; Sladen & Mozdierz, 1989; Paulsen, 1988a; Shybut, 1982). Unfortunately, there are multiple barriers to receiving adequate mental health care in these areas, some which include limited access to and availability of mental health specialists, poverty, geographic and cultural isolation, and the cost of mental health services (National Institute of Mental Health, 2003.).

Many of the demographic statistics of rural health needs, including mental health, speak to a need for increased health services (American Psychological Association, 2003; Campbell & Gordon, 2003). There are a number of reasons for this. First, rates of poverty, underemployment and unemployment are higher in rural areas than in urban areas. Virtually all but a few of the poorest counties in the United States are rural, with a higher percentage of rural poor living in the East South Central

and South Atlantic areas of the United States, both of which are among the areas in the country with the lowest number of psychologists per capita. Next, rural counties have higher percentages of illiteracy, along with fewer resources and services available to schools, compared to urban areas. Substandard housing is also three times more common in rural areas than in urban areas. Furthermore, rural areas tend to have higher numbers of on-the-job accidents and potential hazards due to occupations of mining, farming, and self-employment (DeLeon et al., 1989). These particular occupations, including but not limited to farming, mining, logging and other mill jobs, are more likely to not include benefits such as health insurance or disability insurance; even when there are opportunities to get assistance through local hospitals, there often are not technologically current services (Taylor, 2001).

Finally, compared to urban areas, there are fewer medical and mental health personnel in rural areas. Because of this, medical personnel, who may lack specialized knowledge of social work, counseling, and/or psychology, often fill the role of mental health practitioner. Therefore, there is reason to believe that the quality of life among rural Americans is somewhat impaired. In addition, rural citizens tend to be older, less educated, poorer, and more culturally homogeneous than their urban counterparts (Barbopoulos & Clark, 2003; Greenley & Dottl, 1997; DeLeon, Wakefield, Schultz, Williams, & VandenBos, 1989). There also been a corresponding deterioration of available quality physical and mental health care and insurance coverage and less access to what services are available (Bjorklund & Pippard, 1999). Furthermore, there has been a decline in overall economic prosperity in rural areas (Hargrove & Breazeale, 1993). Poverty is persistent in many rural localities, and this contributes to financial stressors in many rural households, which

is exacerbated by substandard housing and under- or unemployment (DeLeon, Wakefield, Schultz, Williams, & VandenBos, 1989).

The following statement offers reinforcement for the importance of calling attention to the mental health needs of rural individuals. According to the American Psychological Association (1995):

“Because...the leading causes of mortality and disability in rural America are, in large part, behavioral (e.g. accidents, addictive disorders, depression) or lifestyles promoting chronic disease (e.g. cardio-vascular disease), access to psychological interventions is paramount in insuring the health and well-being of rural Americans and reducing and containing health care costs” (electronic version).

### *Rural Stereotypes*

In order to meet the needs of the rural populations, it is necessary to have a thorough basis of understanding of who the individuals and groups are that make up the ‘rural’ segment of the United States. There is, in fact, much variability among rural Americans.

One example of a rural stereotype involves the idea of friendliness, cohesion, and intimacy that pervades rural communities; this is often depicted in literature, film, and is generally assumed to be an ideal of American small towns and villages (Kelly, 1986). Not only is this an exaggeration, but it also seems that the opposite might be true. First of all, rural areas typically have fewer people than in urban areas in a particular geographic radius, and often people have less proximity to one another. Secondly, the small numbers coupled with geographic distance between them can lead to isolation and disconnection. Along with this, the physical distance might result in emotional distance and an emphasis on privacy (Murray & Keller, 1991).

This is not hard to imagine when considering the higher likelihood of people's affairs becoming public knowledge given the smaller amount of people in a rural locality (Kelly, 1986; Benson, 2003). Related is the ideal of sociocultural self-sufficiency, self-reliance and, as a result, the ability to solve one's own problems (Human & Wasem, 1991).

*Psychological Theory as Conceptual Schema: Worldview of Rural Individuals*

It is especially important to ensure that mental health interventions are based more on an ecological level of approach, rather than solely examining the individual level of analysis. In this way, whether a person tends to be more predominantly idiocentric or allocentric, mental health interventions may be applicable, by offering both interventions that are more geared towards the individual unit of analysis, as well as those in which the larger social context is considered. For instance, LaRoche and Turner (2002) found that if allocentric aspects are accentuated with allocentric individuals, they appear to have better treatment compliance. In order to better create theories and interventions related to current rural mental health issues as well as to specific needs of various cultural groups in the United States, exploring self-orientation may be one important piece of this process. Below, the self-orientations of idiocentrism and allocentrism will be defined and explored.

*Self-orientation: idiocentrism and allocentrism.* Triandis (1994) discussed two particular styles of self-orientation that characterize an individual's worldview: idiocentrism and allocentrism. Idiocentrism is a self-orientation that tends to predominate in very individualistic cultures (for example, North America and Western Europe). In this orientation, the self is viewed as autonomous and self-

reliant, independent from the surroundings of interpersonal relations (Triandis, 1989). For individuals with a primarily idiocentric point of view, the goal would be to strive to be independent of other people through paying attention to one's own qualities, and working to hone and express one's unique characteristics (Markus & Kitayama, 1991). The most important aspects of identity would be attributes that lie within an individual, such as "attitudes, emotions, preferences, and beliefs" (Suh, Diener, Oishi, Triandis, 1998, p.484). These attributes are further seen as behavioral determinants, due to the assumption that individuals think and behave based on how they feel and what they believe (Kashima, Siegal, Tanaka, & Kashima, 1992).

Allocentrism, on the other hand, is a worldview that is collective or relational (Triandis, 1994). Within this framework, relationships with other people tend to be more a focus than intrapersonal dynamics, and allocentric people have a self-perception largely based on these relationships. Group goals are seen as more important than individually-minded goals, and social experiences are desired more highly than solitary activities and offer more reinforcement and validation to the individual.

These worldviews might help to explain how individuals in either orientation view life satisfaction and overall well-being. For individuals who are predominantly idiocentric, for example, life satisfaction might be related to experiences that occur within themselves, such as their emotional state or other intrapersonal factors. Allocentric individuals, on the other hand, might experience life satisfaction primarily in relationships with others, in what they are able to do for others or receive from

them, and from conforming to social expectations (Hofstede, 1980; Triandis et al., 1986; Triandis, Bontempo, Villareal, Asia & Lucca, 1988).

Research literature continues to support the importance of matching the tenets of psychological theory that guide interventions, with the values of mental health clients. The value-matching of intervention with the individual appears to have benefits in multiple ways, not limited to increasing the likelihood of treatment compliance and the chance for therapeutic success (Kleinman, 1988; Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994; Triandis, 1995). In this way, matching the worldview of the individual to the mental health treatment being administered is seen to be therapeutically beneficial; the rate of benefit appears to be proportionate to the rate of similarity between the individual and their particular worldview. From here, individuals more often initiate seeking out interventions that most parallel their personal orientation towards self and others, and subsequently gain the most benefit from this (Sue et al, 1991).

#### *Rural Mental Health: Inattention and Inadequacies*

As is evident from above, rural individuals and their mental health do not always receive sufficient mental health attention. Compared to individuals in urban areas, rural individuals have inadequate physical and mental health services (if there is even access to these services), and higher levels of disability and disorders (Henry, Drabenstott & Gibson, 1986). Prevalence rates of mental illness and substance abuse and disability are equal to greater than in urban areas (NIMH, 2000). In fact, the DHHS Bureau of Health Professions states that two-thirds of rural counties are "mental health professional shortage areas." Sixty percent of rural areas are

designated as mental health professions shortages and this represents 75% of the national health profession shortage (Benson, 2003). In understanding the predominant worldview perspective of rural individuals, it is hoped that psychological interventions will be more specifically tailored to this population, providing a foundational step in addressing insufficient mental health care among rural Americans.

### *Overview*

This study examined the worldview of a rural community in terms of idiocentrism and allocentrism, to ascertain whether there is prevalence in one direction or the other. A sample of adults in northern Maine was surveyed on a variety of dimensions, in order to ascertain whether there was a tendency within this particular group towards an orientation more towards self or others.

Given the limited amount of empirical data involving rural American populations, this research sought to fill a gap in existing literature, and to shed light on whether this particular rural group of Americans held a predominance of one worldview over another, or whether there tended to be a more equitable distribution. A rural American population was compared to the general American population examining factors of idiocentrism and allocentrism using two instruments that measure worldview. Additionally, the relationship between demographic factors and the two worldview measures was examined, with the hope of elucidating any overarching themes or trends.

## Chapter II

### *Literature Review*

#### *History of Rural American Mental Health*

At the time of this study in 2007, there were approximately 60 million Americans living in rural parts of the United States. The proportions of people in rural as compared to urban areas have varied over time, and this will be described below.

An examination of the history of rural United States allows for a contextual understanding of current circumstances, and explains why there is a current mental health crisis in rural America (NIMH, 2000). Further, the literature review in this chapter seeks to explore the hypotheses of rural Americans possibly being either more allocentric or idiocentric on the whole. In understanding some general themes of rural United States, the ecology of this population will hopefully become more evident. Such an understanding could help to inform the creation of future mental health interventions.

*United States: rural origins.* The roots of the United States are rural, and they are also recent (Murray and Keller, 1991). In spite of the focus on urbanization of the 1900s, early American history took place in a largely rural society. In fact, the first United States census taken in 1790 showed that 95% of all Americans lived in rural areas (Murray and Keller, 1991). This pattern was largely the norm through 1920, during which there was a continuous flow of migration from rural to more metropolitan areas. Because of these high rates of migration, by 1920, only 50% of

America was considered rural (DeLeon, Wakefield, Schultz, Williams & VandenBos, 1989), a significant decrease from earlier times. This would become salient in future debates over access to resources and services (Murray and Keller, 1991).

Starting in the mid-1950s, there was a new awareness of mental health problems in rural areas of the United States. The Eisenhower administration created a task force to examine rural mental health. At that time, it was found that 60% of rural areas had too few mental health professionals; figures were not cited in relation to urban areas (Benson, 2003). The Eisenhower task force helped to pave the way into the 1960s, when rural American physical and mental health began to be critically examined.

The 1960s were a time of renewed attention to various social ills, including racism, ethnocentrism, and disparities in financial, educational, physical, and mental health opportunities and services (Moynihan, 1969; Wagenfeld, 1988). Starting in the 1960s, research involving urban and rural mental health found deficits among rural populations. Rural areas in the United States reportedly had more poverty, higher levels of disability and disorders, and fewer services to address health difficulties (Wagenfeld, 1988).

Prior to the advent of community mental health centers there was very little focus on rural mental health problems. The act created service delivery areas (catchment areas) so that there would be attention and representation for all areas, including those previously ignored by legislators. The Mental Health Systems Act of 1980 passed by the Carter administration, but not extended by Reagan, would have

been an extension of the above (Wagenfeld, 1988).

Many individuals in the 1960s and 1970s wrote and researched in the area of rural mental health (Caudill, 1964; Wagenfeld, 1988). Leon Ginsberg (1976) referred to the “auditory gap” with regards to the needs of rural American populations being unheard and ignored. In a similar vein, Harrington (1962) stated that the problematic aspects of rural United States, including ecological factors such as poverty, were unseen by society at large.

The 1970s were a notable turning point in the story of rural America. Described by some as “a rural renaissance” or “revival,” the flow of constant migration slowed and eventually stopped, with rural areas starting to grow faster than metropolitan areas. This was occurring for the first time since the start of the 1900s (Zahner, Jacobs, Freeman, & Tainor, 1993). To illustrate, between 1970 and 1974, the counties that were nonmetropolitan grew by 5.6% while those that were metropolitan only grew 3.5%. Despite this apparent “revival,” by 1970, still only 25% of the United States lived in rural areas (Bjorklund & Pippard, 1999). Over 50% of movement in rural areas was due to people moving into rural areas from more urban areas (Bjorklund & Pippard, 1999). Rural growth was largely in non-agricultural areas, which are seven times more prevalent than agricultural areas (Zahner, Jacobs, Freeman, & Tainor, 1993).

Since the late 1970s, there has been much demographic, economic, and social change. Declining numbers of rural people translated into the loss of political influence and power. This decline affected people working in the sectors of food production and farming in the 1970s and 1980s, a notable demographic shift. In

1978, the President's Commission on Mental Health stated that there was a need to assess risk among rural populations for anxiety and mood disorders. This was after acknowledging that conditions in rural areas including inadequate housing, poor schools, and unemployment, put people at risk for mental illness (Rosman & Van Hook, 1998).

The most significant financial circumstance of the 1980s that affected rural life was the farm crisis, introduced to rural America in the mid-1980s. There was an economic depression that was considered the worst since the 1930s. "Poverty streams" were created, affecting people of varying financial circumstances. Already-poor rural individuals were trapped in the depths of poverty from which they were unable to recover. Added to this, the historically non-poor became poor, and there were also poor individuals who lived in urban locales and were unable to afford urban living and thus had to move to rural areas. As unemployment increased, so did the rise of single-parent families. Additionally, there was an increase in service and manufacturing jobs, which were not as financially lucrative (Economic Research Service, 2004). The farm crisis resulted in young people migrating to cities, leaving a large number of elders (Rosman & Van Hook, 1998). Job availability decreased, making farming more difficult, and young people left the areas due to fewer financial opportunities, leaving a weakened tax base.

As a result of the 1980s economic depression, mental health costs were high because of increases in depression, social withdrawal, alcoholism and alcohol consumption, cigarette use, physical aggression, suicide risk for adults and adolescents, high rates of child abuse, familial stressors, and decreased involvement

with community (Paulsen, 1988b). The rural poor moved a significant amount, which resulted in disruptions in relational ties with schools, community agencies, social relationships and connections to mental health services (Fitchen, 1991). Finally, with less public support for social services, mental health services were less funded, if at all (Rosman & Van Hook, 1998).

Rural population growth decreased in the 1980s, but net migration between rural and urban areas remained equivalent (Zahner, Jacobs, Freeman, & Tainor, 1993). As of 1980, 25% or 62.8 million people lived in nonmetropolitan areas. It appears that 1980 was a stopping point for the upward swing of population growth in rural areas. After that, the growth in nonmetropolitan areas dwindled, partly due to the recessions in the farming sector and in the overall slumping economy during the 1980s. The quality of life that rural existence had previously offered decreased sufficiently to not be as attractive a living option. By 1990, the levels of in and out migration were about equal (Zahner, Jacobs, Freeman, & Tainor, 1993).

The 1990s was a continuation of the farm crisis. Economically, there was stagnation and difficult times, with low rates of employment, increasing rates of poverty, and the emergence of “America’s Rural Ghetto”. Today, 90% of the United States is rural but less than 25% of the population lives in rural areas and this continues to decrease over time (Benson, 2003).

The mainstream public had traditionally seen rural America as stable and isolated from dramatic mainstream changes that occurred in urban and suburban United States. However, this was and is not accurate. Given social, economic, and political factors in rural America, there was and is continued risk for psychological

problems and emotional distress. Moreover, the societal shifts provide a challenge to the stereotype of rural environments being homogeneous and well-insulated from the ills of society; the traditional agrarian ideal of “rurality” was challenged, with (not necessarily false) stereotypes including independent males, productivity, conservatism, self-reliance and close relations with neighbors. All of these factors led to the reluctance to utilize mental health services (Hoyt, Conger, Valde, & Weihs, 1997). Given this, it is necessary to develop a thorough understanding about rural self-orientation, in order to maximize the likelihood for people to engage in acknowledgement of distress and seeking treatment. Regardless of whether rural people are more predominantly allocentric or idiocentric, it will be essential for mental health professionals to have an understanding about self-orientation in order to create and implement appropriate and effective interventions.

#### *Defining and Differentiating “Rural” and “Urban”*

Rurality is not well-defined. Usually it is presented as a dichotomy, with little overlap between rural and urban. In actuality, a continuum offers more realistic variation, despite perhaps more complexity (Greenley & Dottl, 1997). As attention to rural mental health has increased, “rigorous explanations of components and definitions of rural” have not been developed (Bosak & Perlman, 1982).

In defining rural, many variables need to be considered. These include occupational and sociocultural factors among others; they need to be addressed ecologically, from the individual to the societal levels (Willits & Bealer, 1967). Components of rurality are not uniform across all people, and cannot be seen as consistent across all rural populations. This helps to explain one of many difficulties

of defining a rural area (Bosak & Perlman, 1982).

*Definition of rural.* The most prevalent definitions of *rural* include those of the Census Bureau, Office of Management and Budgeting (OMB) and Economic Research & Statistics (ERS) (USDA, 2003). Rural areas, according to the U.S. Census Bureau, are “open country” and settlements with less than 2,500 people. Rural areas include land outside of urban areas and clusters. Rural areas are most often nonmetropolitan areas, defined on the basis of counties. According to the OMB (Office Management and Budget), the definition of *nonmetropolitan* areas consists of counties outside the metropolitan area boundaries, including micropolitan areas (urban clusters of 10,000 or more people) and all other non-core counties (Economic Research Service, 2003).

The date of the United States’ last census was in 2000. At that time, there were between 49.2 and 59.1 million American people living in rural areas (or 49%-59%) (Economic Research Service, 2003). Nonmetropolitan United States includes 2,052 counties and consists of 75% of American land and is 17% (49 million) of the United States population (Economic Research Service, 2003). Some rural areas include Midwestern farmlands, Alaskan villages, West Virginian mountains areas, many Southern areas, island villages, and others.

*Limitations of existing definitions of rural.* There are obvious and sometimes more subtle differences, both within and between rural populations. Differences may include population density, ethnic composition, cultural heritages, socioeconomic status, and certain occupations. Mental health practitioners, researchers and policy makers may assume more homogeneity of rural populations than there actually is.

Therefore, rural typologies do not always capture population characteristics relevant to specific research questions or rural areas. Also, rural diversity is increasing, with growing percentages of ethnic minorities settling in rural American areas, which introduces challenges associated with the definition of rural (Spoth, 1997).

*Need for an ecological definition of rural.* The definitions of *rural*, including Census Bureau and OMB, treat all *rural* populations as the same (Spoth, 1997). Thus, there is a need for a better definition and measure. Additionally, the definitions of *nonmetropolitan* and *rural* tend to be based on population, with not much dimensionality to the criteria. All of the above makes diversity hard to capture (Murray and Keller, 1991). There is a need for an ecocultural way of defining *rural*, including the level of economic development, availability of economic resources, people's use of available services, social support and social networks, and overall risk and protective factors for individuals and families.

In a literature review by Sechrest and Walsh (1997), 45% of rural research papers did not define *rural*, with only 35% using quantitative data to define a rural area. Five of 178 reviews used multiple aspects of data to define rural and used quantitative data. This calls for a need of a multidimensional definition of *rural*.

According to Henry, Drabenstott and Gibson (1986):

The rural or nonmetropolitan sector of America is considerably more complex in terms of its demographic and socioeconomic character than is commonly assumed. This means that its economic and human services problems and possible solutions need to be appreciated in terms of the complex and heterogeneous character of the region. (p.8)

This highlights the importance of conceptualizing rural in a way that captures

its complexity and diversity, including whether a region is manufacturing or farming, along with factors such as culture, age of the person, level of income, and distance from cities. All these factors impact the culture of a particular rural area; the diverse aspects of rural areas may inform what self-orientation a particular rural person holds, and which in turn affects the receptiveness of a person to various mental health modalities.

#### *Demography of Rural America*

"Rural Americans have gone from majority, to minority, to curiosity" (Danbom, 1995, p. 248). Currently, approximately twenty eight percent of citizens are living in rural areas, according to the United States Census Bureau. To be rural is sometimes considered triple jeopardy: rural, poor, and uninsured (St. Lawrence & Ndiaye, 1997). The following section describes various demographic trends in rural America that have an undeniable influence upon mental health.

*Social factors of rural populations.* In recent years, rural parts of the United States have become less desirable places to live and work, due to various ecological factors (DeLeon, Wakefield, Schultz, Williams, VandenBos, 1989). Generally, there are fewer kinds of social activity options in rural areas. Those that do exist include spending time with family, participating in school sports, church, work, and going to bars. Teens are more likely to partake in sex and drugs because there is little else to do. Rural areas tend to have more teenage parents, higher rates of sexually transmitted diseases, and more smokers at all ages (Mulder, et al, 2000; Stamm, 2003). All these relate to poorer physical and mental health (Slama, 2004).

Next, the smaller the rural community, the higher the likelihood will be for

conditions such as increased levels of homogeneity, less infrastructure and fewer services, and denser social networks (St. Lawrence & Ndiaye, 1997).

Also, due to geographic isolation in many rural areas, there is the need for self-reliance for survival; scarce economic and social resources force people to meet their own needs (Murray & Keller, 1991). But self-sufficiency tends to decrease when survival depends on outside resources. For example, rural people are often dependent upon close, informal support systems because of the normative value that rural people should care for their own. This has been asserted by many authors (Hargrove, 1986; Kelly, 1986; Murray & Keller, 1991; Human & Wasem, 1991; Barbopoulos & Clark, 2003; Slama, 2004), but unfortunately with little empirical data to back up these assertions. Still, this information may offer support for the hypothesis of rural individuals being more idiocentric in orientation, largely out of necessity and due to the culture of living in sparsely populated rural areas.

Greater distances between people may lead to more dependent living and more interdependence between neighbors and families. This may provide support for the hypothesis of rural Americans being more predominantly allocentric (St. Lawrence & Ndiaye, 1997). However, data on this are scant, and so at this point these assertions are merely hypothetical. This reinforces the need for empirical research that this study hopes to contribute to.

*Racial and ethnic factors of rural populations.* While rural areas tend to be more culturally homogenous than urban areas, there is still notable diversity in rural America. Slama (2004) found to be much diversity within the rural areas, including racial and ethnic composition, incomes, age, and distance from urban areas,

suggesting what is often forgotten, that rural America is quite diverse and holds much within-group variation.

Minorities are a growing percentage of the American population, in both urban and rural areas. As of Census 2000, racial and ethnic minorities consisted of 17% of nonmetropolitan areas, and are becoming more prevalent. Foreign-born residents consist of 3.2% of the rural population (as of 2000), and have a substantial presence in the sectors of agriculture, manufacturing and low-skilled services. The largest minority group in rural areas is African-American. Since 1980, the nonmetropolitan Hispanic-American population in the United States has doubled and is currently the fastest growing group in rural areas (Economic Research Service, 2004). Hispanic-Americans are the fastest growing minority group, with three of four states having rural Hispanic-American growth rates of 50% or greater and almost half of states reporting gains of over 100%. This includes the south and the Midwest. This growth extends beyond traditional states of settlement (i.e. Arizona, California, Colorado, New Mexico, and Texas). Asian-American growth has increased in rural areas due to higher levels of immigration. Asian-Americans also settle outside of original areas of settlement, including higher rates on the east coast and Midwest (Economic Research Service, 2004).

*Family factors in rural populations.* Rural areas in the United States are undergoing a change in familial composition. Historically, large families were the majority in rural areas, so that nuclear and extended families would live close to each other. More recently the trend has shifted from a predominance of large families, to increasing numbers of single-parent families. Also, children are moving away from

rural hometowns, often to seek educational and occupational opportunities, and the family has a subsequent risk for becoming fragmented. This creates the result of an older, more potentially vulnerable rural population (APA, 2003). Other trends involve household size and number of children per household decreasing across all groups. Also, people are also marrying at later ages, and nonmetropolitan people are more apt to be married than urban people across all races and ethnicities, with two-thirds of nonmetropolitan household heads being married (Economic Research Service, 2004).

*Poverty and other economic factors in rural populations.* Rural poverty exists in many regions of the United States, with children and elders being most vulnerable to such stressors (DeLeon, Wakefield, Schultz, Williams, VandenBos, 1989).

The majority of the poor of the United States overall have been found to live in rural areas (DeLeon et al., 1989). These data were confirmed more recently in 1998 by the United States Department of Agriculture, where, once again, higher poverty levels existed in nonmetropolitan areas as compared to urban areas.

The rural underclass in the United States refers to: “High school/college dropouts on public assistance, unmarried mothers, or (if male) suffering long-term unemployment” (Smith, 1998, p.22). In 1990, three million adults ages 19-64 were members of the underclass, with a high percentage of African Americans, Hispanics-Americans, Native Americans, Appalachians, Ozarks, and Caucasians. For people in the underclass, it is difficult to survive with circumstances such as low education, poor health care, unemployment and insufficient or unsafe housing (Jackson & Stewart, 2000). All of these pose as mental health risks.

Overall, there has been a decline in economic prosperity in rural areas

(DeLeon, et al., 1989). More than 800 rural counties (67%) have high poverty rates (Mulder et al, 2000). According to the American Psychological Association (2003), in rural areas 16% of families, 10% of married couples, 42.6% of mother only, and 56.9% families with children are below the poverty line. Women-headed families have highest poverty of all family types (40% in nonmetropolitan versus 34.4% in urban areas) (Mulder et al, 2000). More than 20% of rural children lived in poor families (Mulder et al, 2000).

Today, rural states in the United States have the lowest average income of all states. There is a changing economy in many rural areas, being linked to broader social and economic forces (St. Lawrence & Ndiaye, 1997). There is less work in white collar occupations (versus urban areas), lower incomes, and fewer overall people working in the labor force (Murray & Keller, 1991). Additionally, 67% of United States housing below national standards existed in rural parts of the country (Mulder et al, 2000).

*Occupational status of rural populations.* In rural areas, conventional manufacturing industries have been increasingly moved overseas and high-tech employers are thus more apt to be in rural areas. As a result, new jobs tend to be in low-skilled, low-wage service jobs. Rural areas are experiencing a slow but steady shift from agriculture and mining, to low-end and high-end services such as construction, medicine, social/government services (Economic Research Service, 2004). Additionally, there are higher numbers of small businesses, such as family businesses.

Therefore, there tends to be no fringe benefits, such as social security or

insurance. While no specific data on this are available, with more rural people holding jobs in such sectors as tourism, retail, and fast food, these are occupational categories in which there often is no health insurance, resulting in fewer people who can afford mental health services (Slama, 2004).

Next, rural occupations, such as farming, mining and logging, are more apt to be hazardous (DeLeon, Wakefield, Schultz, Williams, VandenBos, 1989). Additionally, there is more emotional stress related to increased levels of unemployment and poverty. Financial stress is common, due to the occurrence of farm crises and single industry areas (mine or paper mill). Another stressor is unpredictability or uncontrollability of certain factors (i.e. weather, crops, and accidents).

*Educational attainment of rural populations.* There are higher levels of illiteracy in rural areas, and schools, as well as deterioration of special needs services in rural schools (DeLeon, Wakefield, Schultz, Williams, VandenBos, 1989). There is notable lag in rural areas behind cities when it comes to educational attainment: For example, rural residents in 2000 had half the proportion of college graduates (Slama, 2004). Some reasons for lower educational attainment in rural areas include funding, outmigration of more educated people to cities, and lower per capita education spending. Educational attainment is critical for jobs and future financial success, and low schooling levels tend to be detrimental to efforts towards upward mobility (Economic Research Service, 2004; Sladen & Modzierz, 1989).

*Geography of rural America: implications.* Poor rural individuals have less access to services more readily offered in urban areas, such as public transportation to

mental health and other services (Slama, 2004). Many people in rural areas have no driver's license, no car, and perhaps no telephone; in fact oftentimes pay phones are in scarce supply (Mulder, Shellenberger, Streigel, Jumper-Thurman, Danda, Kenkel, Constantine, Sears, Kalodner & Hager, 2000). Greater distances between towns, houses, businesses, etc. pose a potentially significant barrier to accessing social services. In addition, the conventional work week held by mental health and other social service agencies is often inconvenient for people who live at a considerable distance from where the services are offered or who work, so cannot work around such limited days and times (Fox, Blank, Rovnyak & Barnett, 2001).

Weather also greatly influences people whose livelihoods depend upon specific factors, such as farmers. Short-term crises such as droughts, in addition to longer-term economic or social changes in society, could contribute to a deterioration in quality of life for families and communities in rural areas, which ultimately affects mental health (Bergland, 1988).

*Physical and mental health of rural Americans.* Compared to individuals in urban areas, rural individuals have inadequate physical and mental health services (if there is even access to these services), and higher levels of disability and disorders (Henry, Drabentstott & Gibson, 1986). The leading causes of mortality and disability in rural United States are behavioral (accidents, addiction, depression) or lifestyles promoting chronic disease (such as heart disease) (Slama, 2003).

According to Slama (2003) in rural American areas there tends to be higher incidence of chronic illness and AIDS and higher (30-40% higher) rates of teen pregnancy than in urban areas. Additionally, there are higher rates of maternal and

infant mortality, low birth weight rates, chronic illness and disability, morbidity related to diabetes, obesity, cancer, high blood pressure, heart disease, stroke and lung disease, and substance abuse compared to those for people living in urban areas (DeLeon, Wakefield, Schultz, Williams, VandenBos, 1989). Rural areas lack specialized services such as speech and language, women's shelters, elder programs, and child care (Barbopoulos & Clark, 2003).

People in rural America are more likely to not have health insurance, to not have a health care provider, and to experience more chronic and acute illnesses, all compared to urban people (Sawyer, 2001). Added to this, there are 605 United States counties that do not have a medical health care provider, while 1,600 counties do not have a mental health provider. This relates to there being less federal and more state/local regulation regarding policy over rural conditions. Also, there has been service deterioration due to uneven provider distribution (Rosman, Van Hook, 1998). Next, with an older population, there are higher instances of dependence upon Medicare, resulting in lower reimbursement rates for health services, thus making the provision of healthcare more difficult (Slama, 2004). Mental health care in rural areas historically was public, and now Medicaid is privatizing under managed care contracts (Rosman & VanHook, 1998).

With regard to crime and other antisocial behaviors, rural men and women are more likely to use firearms in murders and suicide compared to urban people. High levels of rurality, often mixed with poverty, are associated with higher rates of murder in the United States (Mulder et al, 2000). Living in a small community means that victims and perpetrators might be involved in familial and other nonprofessional

relationships with emergency response people. Multiple relationships and lack of anonymity minimizes confidentiality, and the way to be objective in such situations (Mulder et al, 2000).

The DHHS Bureau of Health Professions states that two-thirds of rural counties are "mental health professional shortage areas" (Benson 2003). Sixty percent of rural areas are designated as mental health professions shortages, and this represents 75% of the national health profession shortage. There is a limited amount of published material regarding interdisciplinary collaboration of behavioral health care in rural areas. However, the literature that does exist suggests that 20% of United States residents live in rural areas, which also often happen to be areas of shortage (MHPSAs). Women, children, Native Americans, migrant and seasonal farm workers are at particular risk for physical and mental health problems. In rural and frontier family practice clinics, 50-70% of patients have symptoms that are somehow related to, or caused by behavioral health problems (American Psychological Association, 2003).

As a result of rural areas being dramatically underserved by mental health providers, the primary care physician might be the only health provider meeting with a rural individual to deal with either physical or mental health problems (Sears, Danda, & Evans 1999). There is an additional challenge in integrating primary care physicians with mental health care providers, given that so many clients report to their physicians symptoms that are related to mental health (Sawyer, 2001). Often, these primary care doctors do not deal sufficiently with social, emotional and psychological needs of people, because of their orientation to medical care

(Weisgrau, 1995; Bader, Ackerson, Buttell, Rand, 1997).

Psychological complaints comprise over 40% of all patient visits to rural primary care physicians, yet these primary care physicians (PCPs) detect 50% less depression in patients than do urban PCPs (Katon & Schulberg, 1992).

Therefore, there are high rates (50-80%) of underdiagnosis and misdiagnosis (Badger, Robinson, & Harley, 1999). If people do not seek their primary care doctors, they might go without mental health care altogether. Furthermore, rural areas are less likely to have inpatient mental health facilities compared to urban areas.

*Summary.* Rural United States generally has serious and persistent problems, including poverty, economic vulnerability, reduced funding and access to/for physical and mental health services, and reduction of quality of health care (DeLeon, Wakefield, Schultz, Williams, VandenBos, 1989). Rural Americans as a group tend to be older, less educated, and more homogenous in terms of race and ethnicity. There are also more vulnerable demographic groups, such as teens, elders, and working mothers in rural areas. Also, poverty is characteristic, and there is more unemployment, more hazardous occupations such as farming, mining, logging, overcrowded or insufficient housing and less likelihood of having health insurance. These all pose challenges in helping rural individuals to recognize and access mental health services, which are needed for a significant portion of the rural American population. This makes it essential to continue to elucidate those factors that facilitate the ability and willingness for people to seek such services. The reason for including demographic information regarding rural Americans, is to point to: 1) the variability among and between rural individuals in the United States; 2) the many

challenges faced by rural people that indicate the necessity for mental health researchers and practitioners to pay attention to this segment of the population; and 3) the importance of ascertaining worldview orientation so that professionals will be better equipped to include this as a factor in mental health treatment.

### *Rural American Mental Health*

"Rural people feel powerless and disenfranchised because they are powerless and disenfranchised" (Dyer, 1997, p.369). The following section will offer an in-depth exploration of rural mental health. From there it will hopefully evidence the imperative for paying more attention to this complex and diverse subgroup of the United States.

*Barriers to rural mental health services.* There are unmet mental health needs in traditionally underserved groups including elders, race/ethnic minorities, uninsured and rural individuals (Mahoney, 2005).

In rural practice, personal and professional roles can be unintentionally blurred, with codes and rules not being automatic and always crystal-clear. There are often complex dual, multiple, and/or simultaneous relationships, with mental health professionals often being faced with treating family members and friends of clients (Schank & Skovholt, 1997). It is thought that there is more potential for conflict in rural practice than in urban practice, given the difficulties involving formalities within ethics and rules within the profession conflicting with the often informal expectations (Schank & Skovholt, 1997). Boundary issues are of great concern in rural areas because of the small number of people in overlapping relationships (Barbopoulos & Clark, 2003).

There is also limited use of paraprofessionals, and a low number of self-help organizations, (Bjorklund & Pippard, 1999). Recall above where rural areas were described as “mental health professional shortage areas” (Benson, 2003). Related to this, there are fewer rural clinicians (including social workers, psychiatric nurses, and especially psychologists) than in urban areas, and rural clinicians and paraprofessionals tend to have less training experience and are less apt to be licensed. Even with the same amount of training, there are fewer academic programs that offer training specifically geared towards rural areas. There are also fewer higher education mental health programs specifically located in rural areas, offering fewer opportunities for practicum and internship opportunities with rural populations; exact statistics were not offered by these authors (Barbopoulos & Clark, 2003; Bjorklund & Pippard, 1999).

Additionally, the public mental health system often is the sole provider in rural areas so there is a need to travel long distances and people often see less trained providers. As a result, rural individuals will often seek mental health care from ministers, self-help groups, family, and friends. This care is often neither comprehensive nor sufficient (Mulder et al, 2000). Rural psychologists therefore need to play a more generalist role due to having a fewer number of available clinicians in rural areas (Slama, 2004).

The need for rural generalists, along with the unique economic and social circumstances of rural areas, all require different approaches to mental health. These areas need practitioners who fill a wide range of needs in a smaller structure of organization. Rural mental health professionals tend to be strongly oriented to

community and see it necessary to be flexible in their community involvement. (Psychology & Rural America: Current status and future directions, 2003). Availability and accessibility of services are negatively affected by not having enough health care personnel or facilities, and less private health insurance (Anderson & Gittler, 2005). Given the needs of clients, generalists may be more capable of offering the full range of needs (Barbopoulos & Clark, 2003).

Mental health facilities and providers are lacking in rural areas (Badger, Robinson, & Harley, 1999). There tends to be a wide distribution of people across vast areas, making it difficult to organize community development or service delivery. For example, a typical rural mental health service delivery area is 5,000 square miles and the largest area is 60,000 miles (Stamm, 2003). In any given area, there might only be one mental health center for a very large catchment area (Solomon, Hiesberg & Winer, 1981).

Additionally, it may be difficult for rural clients to work comfortably with mental health providers who may not be aware of the cultural aspects related to being from a rural area. This is similar to what may occur with ethnic and racial minority groups. For example, isolation and lack of privacy may create an ethic of keeping problems within the family, which could potentially worsen problems (Slama, 2004).

Another important factor that forms a barrier to mental health treatment for rural individuals consists of premature termination/client drop-out of mental health services. Owen and Kohulek (1981) examined clients in rural areas and found a significant rate of premature termination.

Another rural characteristic is the tendency to look towards the system of

family, religion, or primary medicine, as an antidote for mental health problems, something that may support the idea of allocentrism in rural areas (Slama, 2003). Often out of necessity, “Mental health problems are typically considered the domain of family and church” (Fox, Merwin, & Blank, 1995, p.442). This de facto mental health system, comprised of religious and faith healers, self-help groups, family, friends, or other social supports, is often relied upon (Fox, Merwin & Blank, 1995; Arcury, Quandt, McDonald, & Bell, 2000).

Deinstitutionalization is another barrier to mental health services; there are few resources in rural areas to help the chronic mentally ill who had been institutionalized. With high vulnerability to stress, excessive dependencies, limited coping skills of chronically mentally ill, it places a high burden on the social system (Psychology & Rural America: Current status and future directions, 2003). A landmark work on this topic was published in 1969, aptly titled *Mental Health Services for All Americans: The Challenge of Rural Mental Health* (U.S. Department of Health, Education, and Welfare, 1969). In this publication, authors noted that of 14 counties in rural America, only one had a general hospital equipped with a mental health clinic; conversely, one in three urban counties had such facilities. Of all the mental health clinics discussed, only 10% of them were located in rural areas, and of those, many were only operating on a part-time basis. Additionally, compared to the four most urban states, the four most rural states had one-tenth the ratio of mental health beds per 1,000 people (USDHEW, 1973).

*Mental illness in Rural America.* Today, mental health risk is still a problem in rural areas of the United States. Stressful life events unique to rural areas are

linked to depression/worthlessness, high rates of stress due to limited access to resources required to meet both personal and interpersonal needs (USDA, 1998; Mulder et al, 2000). Some factors associated with rural depression include many demographic factors described above: isolation associated with rural life affecting both social supports as well as access to mental health services, weather problems, declining farm economy with resulting unpredictable and irregular income and lack of social, educational and child care resources. Rural women also report higher levels of psychological distress, especially depression, than men. This may be due to socio-demographic variables as well as the nature and extent of multiple roles assumed by women (Mulder et al, 2000).

In each area of the United States, suicide rates are higher in rural/nonmetropolitan areas (for both adults and children). Some factors leading to suicide in rural areas include rural stress, such as a farming crisis, the experience of loss (loss of political power, community, livelihood, etc), untreated mental illness, and lack of mental health services or lack of available services and social isolation (Bjorklund & Pippard, 1999; Elliot-Schmidt & Strong, 1997; Beeson, 1991).

Psychological distress is expressed in various ways, such as domestic violence, child abuse, and suicide, all of which have increased exponentially in rural areas since the 1980s. The tendency for rural people to suppress emotional expression and thus somaticize symptoms is a fairly common phenomenon. For example, the Eastern Kentucky Syndrome, in which miners reported aches, pains, and feelings of being smothered (Barbopoulos & Clark, 2003; Slama, 2004).

Mood and anxiety disorders are two of the most common forms of mental

illness in the United States (Badger, Ackerson, Buttell & Rand, 1997). The most common studied mental health disorder in rural areas is depression. In fact, depression is the most significant presenting mental health issue in rural primary medical care. Factors linked to depression include younger age, unemployment, and lower levels of education (Mulder et al, 2000). Diagnosis is confounded by poorly defined symptoms, somatic symptom reports, and comorbidity with medical illnesses. Those physicians who recognize depression cannot always refer out due to few services available in rural areas, and even then there might be resistance on the part of clients (Badger, Robinson, & Harley, 1999).

*Rural mental health research.* Consistent with the inattention to rural mental health needs, including insufficient promotion of mental health in the United States, basic descriptive and preventive research on rural mental health needs is sparse (Fried, Johnson, Starrett, Calloway, & Morrissey, 1998). This is especially problematic given that rural people are a silent minority due to geographic dispersion and lack of cohesive governmental representation so (Psychology and rural America: current status and future directions, 1993; St. Lawrence & Ndiaye, 1997). Research literature involving mental health in rural areas has been divided into four areas, according to Murray (1984).

- First, the ecological comparison of rural to urban populations, typically highlighting the differences between the two;
- The statement of need regarding the creation of new conceptual models, since rural mental health issues differ from those in urban mental health;
- Rural mental health clinicians are repeatedly referred to as generalists, and the

literature supports this policy. Qualities of clinicians also cited as being important include flexibility and independence;

- Community research and new training and/or practice models of rural mental health are needed.

While research on rural America is notably sparse, what does exist has been epidemiological, involving rural/urban differences in the prevalence of mental disorders or their symptoms (Spoth, 1997). Beeson (1992) states: “The question is whether there is something specific to rural that contributes to problems ...or whether the structural effects of rapid social change, economic distress, and the decay of social institutions (regardless of geographic setting) give rise to stress-induced mental disorders” (p.3). Spoth (1997) thus concludes that it is vital to know the ways that “rural” differs from “urban” regarding prevalence of mental illness, in order to create preventive interventions.

Most etiological modeling for prevention has been with urban populations and it is unclear how much can be generalized to urban locations. In specific rural areas, often there is no specific prevalence data (problem or place) and there often are few, if any, data collection resources. Much epidemiological research comparing urban and rural areas is on the topic of in overall levels of disorder problems, with much less research on specific topics. Since studies on severe mental illness are typically conducted on urban samples, little is known regarding the characteristics and needs of rural individuals struggling with severe mental illness (Bjorklund & Pippard, 1999).

For rural researchers, it is important to understand social, lifestyle, organizational, institutional factors in rural areas and adapt research to the rural

ecology (St. Lawrence & Ndiaye, 1997). According to the office of Rural Mental Health, rural research has not been a federal funding priority (Bjorklund & Pippard, 1999). There are a significant number of people with severe and chronic mental illness who live in rural areas, but programs have historically ignored this population with regard to design and implementation of mental health services. Instead, people focus upon urban research, because data are available from these areas (Bjorklund & Pippard, 1999; Muehrer, 1997). Fortunately, in recent years psychology has focused more on rural issues including organizations and groups such as Alliance for the Mentally Ill (AMI), the Mental Health Association (MHA), APA Rural Health Task Force, Office of Rural Health, Rural Health Bulletin, Rural Psychology ([www.apa.org/rural/](http://www.apa.org/rural/)) (Mental Health Services in Rural America, 2000).

It is the aim of this proposed research to add to existing understanding of people living in rural areas, in order to increase the ability of mental health providers, to address individual needs more effectively. In gaining a more thorough understanding of self-orientation in one group of rural individuals, this will hopefully lead to future research of self-orientation among various other diverse groups of rural Americans.

#### *The Culture of Rurality: A Diversity Issue*

The issue of rural America can be viewed as one of diversity, existing along an acculturation continuum within mainstream culture, differing in the degree of adherence to rural values, traditions, and customs. Rural areas are not homogenous; it is important to recognize that traditions and customs vary in kind from town to town, and area to area. Each locale's culture depends on the particular geography, customs

and traditions; these in turn affect thinking and acting. Additionally, there tends to be variability across areas with different degrees and types of rurality, which highlights the need to be sensitive to differences between rural areas (i.e. regional differences/variations in ethnicity, economics, and historical factors (Dottl & Greenley, 1997).

Since the 1990s, there has been an awareness of the fact that rural people get less help than urban people in terms of treatment for mental illness including the APA committee on Rural Health report (American Psychological Association, 2003). According to Stamm (2003) “urbancentrism” consists of a “tendency for psychologists and other professionals as well as the general public, to pay more attention to the problems of cities and suburbs than to those of rural areas” (p.158). Urbancentrism has also been referred to as “metrocentrism” (Nordal, Copans and Stamm, 2003), whereby “[l]egislators need to know that national policies are often based only on urban models and do not provide an accurate picture of rural areas...models of funding and care must take rural factors into account” (Slama, 2004). According to the National Institute of Mental Health (2003, electronic version):

While groups such as...the Alliance for the Mental Ill (AMI), the Mental Health Association (MHA) and many others have begun to play a much more significant role in advocacy across the mental health system, these groups have shown little interest in the rural environment. Consumer involvement is discussed frequently in the literature, yet its rural component is addressed only in a limited way.

*Cultural competence.* There has been a call for mental health providers to be culturally competent and to respond to and acknowledge the existence of concerns, histories, traditions, beliefs and values of ethnic and racial groups. Cultural

competence is defined as: “[A] set of behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables that system, agency, or professionals to work effectively in cross-cultural situations (Cross, 1989). According to this definition, there are three ways of achieving cultural competence: first, to make mainstream treatments more inviting and accessible to minorities through greater awareness and better communication; second, to select a “traditional” therapeutic approach according to the perceived needs of the group; and third to adapt available therapeutic approaches to the needs of the minority group. Ridley, Mendoza, Kanitz, Angermeier, Zenk, 1994).

According to cultural match theory, cultural sensitive therapy (CST) states that we adhere and benefit from treatment that is more congruent with our beliefs and narratives. CST offers the delivery of treatment that is responsive to cultural concerns of a minority, accounting for a client's language, history, tradition, belief, and values. To design CSTs, it is insufficient to look only at race and ethnicity; this falsely assumes that other dependent variables in a culture are homogenous and it ignores intragroup differences (Triandis, 1995).

More specifically, research (Rosselo & Bernal, 1999; Sue, 1991) has shown that interventions are more effective if they are congruent with one’s self-orientation (for example, allocentric individuals tend to improve more effectively with an allocentric intervention versus an idiocentric intervention). In this research, it is hoped that important aspects of rural worldview and self-view will be revealed, leading potentially to improved interventions.

*Introduction to Worldviews and Self Orientation*

*Worldview.* The definition of *worldview* consists of a foundational perspective: How a person perceives and understands their world at the most basic of levels (Sue 1991). Inclusive of worldview are: "...[V]iews about basic human nature, families, intimate and social relationships, locus of control, time, space, and activity." (Okun, Fried, and Okun, 1999, p.12).

*Self-orientation.* According to Triandis (1994), self-orientation is the overall tendency for individuals to see self and the world in a certain way. Within this overarching way of looking at the world and oneself, Triandis divides individuals into two orientations of self, with one usually predominating over the other. Triandis (1994) additionally has found these orientations to be stable and consistent over time and across various contexts, and are seen to be independent from one another (LaRoche & Turner, 2002 and Triandis, 1994).

Two ways of orientating oneself to the world involve the constructs of individualism and collectivism. According to Hofstede (1980): individualism and collectivism are one bipolar dimension of national culture, and they can both co-exist within a person; even though cultures appear to have a tendency towards one self-orientation over the other, there is variability within cultures, where not all individualistic cultures will be comprised of only idiocentric individuals; similarly not all collectivistic cultures will have solely allocentric individuals.

*Individualism.* Individualism classifies societies and cultures in which goals pertaining to the person predominate over goals pertaining to the collective group (Triandis, Bontempo, Villareal, Asai, & Lucca, 1988). Higher rates of individualism

have been seen to occur in the people of North America and Europe (Hofstede, 1980; Triandis et al., 1986; Triandis, Bontempo, Villareal, Asia & Lucca, 1988).

*Idiocentrism.* Idiocentrism is the individual level of the societal construct of individualism. In this orientation, the self is viewed as autonomous and self-reliant, independent from the surroundings of interpersonal relations (Triandis, 1989). Similarly, the goal would be to strive to be independent of other people through paying attention to one's own qualities, and working to hone and express one's inner characteristics that are unique to him/her (Markus & Kitayama, 1991). Idiocentric individuals extract their identity from self-involved situations that accentuate definitive boundaries from others, and goals set for themselves (Sinha & Verma, 1994).

As a consequence related to such individualistic ventures, idiocentrics tend to report being lonelier and have lower subjective well-being than allocentric individuals (Triandis, Leung, Villareal, and Clack, 1985). These traits tend to be stable and consistent over time (contextual and are independent from each other).

*Collectivism.* Collectivism classifies societies and cultures in which goals pertaining to the collective group are either equal to or greater than personal goals (Triandis, Bontempo, Villareal, Asai, & Lucca, 1988). Higher rates of collectivism have been seen to occur in Asian and Latin American cultures (Hofstede, 1980; Triandis et al., 1986; Triandis, Bontempo, Villareal, Asia, & Lucca, 1988). It is estimated that approximately 66% of the world's human population exist in collectivist cultural realms, where boundaries surrounding the individual self are not so firmly established (Triandis, 1995).

*Allocentrism.* Allocentrism is the individual variable of the societal construct of collectivism. According to Triandis (1994), allocentrism consists of the following: 1) self is defined by the ingroup; 2) ingroup goals are more important than personal goals; 3) ingroup memberships are few, close and important; 4) integrity of ingroup is important. The way that they understand themselves is in terms of what they have in common and connection with others; group goals rather than individual goals are thus sought after (Triandis, 1994).

In summary, the self-representations of idiocentrism and allocentrism are influenced by the culture-at-large, and this has a tremendous effect on how individuals conceptualize themselves and others. (Miller, 1994; Morris & Peng, 1994).

#### *Demographic Variables and Self-Orientation*

The following section will offer a summary of available information found in literature involving individualism and collectivism, with regard to specific demographic variables. While age, education, sex, number of close friends did not appear to correlate with a particular self-orientation, religion and ethnicity have been linked in research literature with prevalence in specific directions. For example, American and British-influenced areas have reported higher levels of idiocentrism, while countries that were more Latin, Mediterranean or Asian reported higher prevalence of allocentric tendencies (Hofstede, 1980; Inglehart & Oyserman, 2003; Triandis, Bontempo, Villareal, Asai, & Lucca, 1988). In terms of religion, as far back as the early 20<sup>th</sup> century, Weber (1904; 1958) found that individualism has been

linked with Protestant faiths, while allocentric individuals were more linked with Catholic faiths.

*Age.* Available studies examining prevalence of idiocentrism and allocentrism have often looked at populations within universities (Triandis & Gelfand, 1998; Carpenter & Radhakrishnan, 2002). In these instances, the mean age of subjects has been approximately 20 years. One study that offered a more comprehensive age range had the average age of a subject as being 30 years old, ranging between 18 and 86 years of age (Gouveia, Clemente, & Espinosa, 2003). In another study, the average age of a Chinese sample was 33, in being compared to a United States sample where the average age was 42 (Wang, Lawler, Walumbwa & Shi, 2004). Next, Schaubroeck et al (2000) compared two samples where the mean age was 24.8 and ages ranged between 20 and 36.

*Education level.* The majority of study samples in the available literature had participants who had at least high school degrees and many had at least some university education. For example, in Schaubroeck's et al (2000) study, 96 % of the participants had a high school degree, and 8% had an undergraduate degree. Wang, Lawler, Walumbwa and Shi (2004) worked with a sample of Chinese and American participants, 93% of whom were currently enrolled or had graduated to college. Carpenter & Radhakrishnan (2002) study included 198 undergraduates.

*Sex.* Available studies found an overall comparable distribution of men and women sampled (Gouveia, Clemente, & Espinosa, 2003); Triandis & Gelfand, 1998). The most unevenly distributed study found was that of Schaubroeck et al (2000), where in Hong Kong and American samples, 89% of participants were female.

Wang, Lawler, Walumbwa & Shi (2004) had a 64% average of women in their study samples (74% female in the American sample, 56% in their Chinese sample). Carpenter & Radhakrishnan (2002) had 30 women and 47 men in one sample, and 57 females and 65 males in another study sample.

*Number of close friends.* Only one study available specifically described study participants' reports on friendships. Gouveia, Clementa, & Espinosa (2003) found that participants reported mostly stable friendships, with on average, four good friends and six acquaintances in the last year. This study sample was found on the whole to have more allocentric than idiocentric leanings.

*Religiosity.* Gouveia, Clemente & Espinosa (2003) sampled a study population in which 71% of the sample was Catholic. Overall, this group reported a low degree of religious beliefs. Next, Singelis et al (1995) found that of 267 study subjects, 200 reported that they were Christian, while 61 of subjects reported subscribing to rationalism (defined as "a skepticism about religion or no religion") (Singelis et al., 1995, p.253).

*Relationship status.* Only one study offered information regarding this factor. Gouveia, Clemente & Espinosa (2003) reported that 70% of their study population was unmarried. Research literature indicates that allocentrism has been linked to happier marriages (Triandis, Bontempo, Villareal, Asai & Lucca (1998). Interestingly, the Spanish population sampled in Gouveia et al's study was found to have a higher prevalence of allocentric than idiocentric individuals.

*Household number.* No studies found included information regarding number of individuals in the households of study participants.

*Ethnicity.* As mentioned above, Gouveia, Clemente & Espinosa (2003) studied a Spanish sample of 526 individuals, including 290 in undergraduate university and 236 in the general Spanish population. The participants were generally found to be higher in collectivism than individualism. Hofstede (1980) studied populations of United States, Australia and Canada and found high rates of individualism. Triandis & Gelfand (1998) conducted two studies, one with 326 South Korean university students, and one with 127 Illinois undergraduate students. Triandis, McCusker & Hui (1990) found higher rates of individualism in United States, Britain, and British-influenced countries such as Australia. They also found higher rates of collectivism in Africa, Asia, and Latin America. In Carpenter & Radhakrishnan's 2002 study, they sampled 77 Hispanic and 121 non-Hispanic Caucasians.

*Idiocentrism and allocentrism in rural U.S.: worldview.* To date, there has been little research in examining idiocentrism and allocentrism within American rural communities. With anonymity being less of an option in rural areas, isolation and greater distances between individuals in rural areas could be argued to facilitate greater interdependence (Brownlee, 1996). At the same time, this same isolation might lead individuals to develop a self orientation that is not other-focused and that puts more emphasis on self-reliance. This study intends to assess worldview orientation among a population in Northern Maine, which will then hopefully guide the establishment and more culturally congruent mental health interventions.

*Study Summary: Research Questions*

The need for more empirical research involving rural American populations in terms of mental health needs is great. Exploring self-orientation in rural populations could be potentially an important tool in critically examining and understanding rural mental health needs. Such an understanding would increase cultural competence and the ability to attend to the values of clientele. For example, in ascertaining a predominance of idiocentric worldviews among a particular population, mental health interventions that are more oriented to the individual's goals and insights may be more congruent with their values and preferences. On the other hand, a predominance of allocentric worldviews may indicate the usefulness of incorporating a more ecological and/or community-oriented approach to mental health interventions, perhaps involving systems such as the family into a client's treatment.

The primary research area that was explored, based on the above literature review, is whether rural Americans show a tendency to be more allocentric or idiocentric. This was done through objective measures of these traits, as will be discussed in the next chapter.

One rural population was examined in this study, due in part to its relative inattention in the larger system American mental health, and also in part due to the central importance of understanding worldview in the context of a mental health client's individual presenting issues. This research was not necessarily be generalizeable to all rural American populations, as the diversity among and between rural populations is known to be considerable. Still, in ascertaining self-orientation among one specific group of rural individuals, it is a building block upon which other

studies may follow. Additionally, because mental health literature indicates evidence of minimal consideration of allocentric mental health interventions, it was hoped that this study would lend more strength to the argument for more allocentric ways of addressing mental health needs.

The goal of this research was to explore in an open way how rural Americans view themselves and the world around them. That is, whether people in rural areas approach the world from a more predominantly individualistic or collectivist focus.

This chapter's literature review was intended to illustrate contextual history with regard to rural United States, with highlights around aspects that affect mental health, both directly and indirectly. What is widely known about rural America, as espoused in academic literature, is that there are significant mental health concerns for this vastly diverse sector of society, at least in part due to many years of insufficient attention paid to this "silent minority".

As a result, this research served as a contribution to existing academic explorations. In studying rural self-orientation, it was hoped that it would bring rural myth directly in the face of rigorous statistical measurement, with a goal of working towards cultural competence and mental health interventions that are more aligned with rural culture, whether individuals are more predominantly idiocentric or allocentric in self-orientation.

## Chapter III

### *Research Methods and Design*

#### *Scientific and Research Methods*

This research study was predominantly exploratory in nature. A review of the literature showed little research available that examines the worldview of rural individuals. Multicultural research has cited worldview orientations such as allocentrism and idiocentrism as being important factors in differentiating various ethnic and racial groups (Sue & Sue, 2003), but no studies have examined these variables among rural American cultures. The intent of this research was to provide information that will lead to an ultimate provision of improved mental health services for rural populations by exploring their worldview in terms of allocentrism and idiocentrism.

#### *Research Questions*

The specific research questions for this study included the following:

1. How does a sample of adults from rural Maine compare to the general U.S. population in idiocentrism and allocentrism, as measured by the Individualism-Collectivism (INDCOL) measure and the Shweder-Bourne measure?
2. What is the relationship between idiocentrism and allocentrism scores on the INDCOL and the idiocentrism and allocentrism scores on the Shweder-Bourne measure?

3. What is the relationship between selected participant characteristics and idiocentrism/allocentrism scores from the INDCOL, and dimensions on the Shweder-Bourne measure of idiocentrism/allocentrism?

### *Participants*

A total of 114 Maine residents responded to this survey. Of this total, 26 did not meet selection criterion for living in towns of 2,500 people or less and were eliminated from the final analyses.

This final sample consisted of 88 people, 41 (46.6%) men and 47 (53.4%) women. This sample met the criteria for a rural area, having the requisite number of people (fewer than 2,500) and living outside of urban areas and clusters. Sample statistics were fairly consistent with Maine population statistics, where males are 49%, and women are 51% of the total state population (U.S. Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Matrices PL1 and PL2).

The participants ranged in age from 21 to 83 years of age, with mean sample age being 42.5 years. This is consistent with Maine's median state resident age of 41.2 years (U.S. Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Matrices PL1 and PL2).

With regard to ethnocultural background, 96.6% of respondents (n=85) reported being non-Hispanic White, eight percent of which also reported being of French descent (n=7). The remaining 3.4% (n=3) reported being of American Indian heritage. There were no other ethnicities reported. No data analysis was performed for ethnocultural background because of the very small numbers who were not non-Hispanic White.

Currently, ethnocultural percentages in Maine consist of 97% Caucasian, .5% report being American Indian and Alaska Native (U.S. Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Matrices PL1 and PL2.) Therefore, the percentages obtained in this survey were similar to the breakdown in the state of Maine, thus suggesting that research results, with 96.6% non-Hispanic White and 3.4% American Indian, were approximately representative of the population of the state of Maine.

*Recruitment of participants.* Two methods of data collections were used in this study. Initially, four Elks Clubs in central and northern Maine agreed to participate in disseminating 20 questionnaire packets each, to willing Elks Lodge members (see Telephone Script, Appendix A). Three other lodges were also solicited but did not agree to participate. Four weeks after survey distribution, three of four lodges reported no success in obtaining completed surveys, and the remaining lodge had acquired only six protocols, well below the target goal of 80 protocols. Possible reasons for this may include the lack of face-to-face follow-through which might have increased accountability, along with organizational conflict and busy schedules as reported by Elks Club leaders.

At this point, due to such low returns, it was hypothesized by this researcher that a more aggressive manner of data collection would be required, perhaps necessitating face-to-face solicitation. This seemed especially pertinent given previous attempts with data collection that were more based on telephone and written correspondence. Thus, the next phase of sample selection involved this researcher obtaining permission (as well as IRB clearance) from a centrally located surplus and

salvage chain store. Volunteer research participants were recruited from outside the store. This researcher solicited for a period of 3.5 weeks, from 5-8 pm, Mondays through Fridays.

### *Procedure*

Each potential study participant was provided an unsigned informed consent form (Appendix B). It included the purpose of the study, confidentiality issues, potential risks and benefits of participating in the study. Willing participants were provided a packet of three questionnaires to complete. Each questionnaire packet provided anonymity, including numbers assigned to the protocols. Participants' full names did not appear on any documentation or study material. The above procedure was completed in its entirety by this researcher.

### *Research Questions and Analyses*

*Measures.* Each of the following measures was included in each participant's questionnaire packet.

1. *Demographic survey* (see Appendix C) developed by the researcher for the purposes of this study. This consisted of questions on gender, age, race and ethnicity, relationship status, number of people in household, level of education, level of income, number of close friends, involvement in social events with friends and/or family, and whether there was involvement in attending organized religion events such as church or temple.

2. *The Individualism-Collectivism (INDCOL) Scale* (see Appendix D) originally established by Hui (1988), and revised by Singelis, Triandis, Bhawuk, & Gelfand (1996) was used to measure the constructs of individualism and collectivism.

Two versions, Chinese and English, were created, with translation of items from the INDCOL occurring simultaneously, thereby each version being equally original. From the translation, a pool of 96 items (eight subscales, including Family, Acquaintance, Spouse, Parent, Kin, Neighbor, Friend, and Co-worker) was decided upon. Overtime, the items were reduced to 63, when the Cronbach alphas of the Family (.18) and Acquaintance (.08) subscales were deemed to be too low, along with certain items from other subscales that were excluded to help raise reliability levels for the instrument. The scale was established as a six-point Likert instrument, with ratings from 0-5 (strongly disagree/false to strongly agree/true). The original group to be administered the INDCOL consisted of 108 Chinese university students in Hong Kong and 132 American college students in Illinois. While these groups were vastly different in terms of culture and language, all individuals had similar levels of education and this exposure included considerable individualist influences. For both groups, individualist and collectivist ideologies were part of their lives. For example, the Hong Kong Chinese lived in a capitalist (and thereby largely individualist) society, while also being from a collectivist Chinese culture. On the other hand, the American participants were exposed to American individualism but also the collectivist values of small, Midwestern communities. This allowed for variance to exist in both study samples, thereby drawing a fairly equivalent comparison to this study's proposed research sample (Hui, 1988).

Results from the original study found that the INDCOL did indeed measure individualism and collectivism in an accurate manner. To establish reliability, the author administered the INDCOL for a second time, two weeks after the original

administration, with some minor changes to allow for improvements. Most of the subscales were found to have reliability coefficients in the area of .60, which, due to the construct's complexity, was decided to be a satisfactory value. Following this, the author conducted six validation studies. First, expert judgment was established to be valid, across researchers in differing cultures. Next, validation studies were conducted involving social interest, need for approval, obligation-intention correspondence, and responsibility sharing found that the instrument displayed construct validity. The collectivist construct that is examined in the INDCOL was found to be related to social interest, but not synonymous with self-sacrifice. Collectivism was also found to be predictive of one's ability to share responsibility, and related to the congruence between perceived obligation and the intention to behave accordingly. Based on these original scores, collectivism was found to be more valued in Chinese culture than in American culture. Also, according to Triandis et al (1985), in examining scales measuring similar constructs, the INDCOL scale was found to have discriminant validity from those instruments.

The INDCOL currently has two sub-scales, each comprised of 16 questions, one for allocentrism (the individual variable of collectivism) and one for idiocentrism (the individual variable of individualism). This measure was used to assess levels of allocentrism and idiocentrism of the research participants, and the validation group for the original study (Hui, 1988) was compared to this research sample, in order to ascertain whether participants are high or low on these variables, compared to the original research sample.

In the research sample of the revised INDCOL (Singelis, et al, 1995), participants included 96 University of Illinois students and 171 University of Hawaii students. There were 109 men and 156 women, with an average age of 23, and a range of 18 to 55 years. There was varied ethnicity, with the highest frequencies including East Asian and Western European individuals (87 and 59, respectively). The highest frequency of stated religious beliefs included Christian (n=200). Rationalism (defined as “a skepticism about religion or no religion” (Singelis, et al, 1995, p.253) was of the second highest frequency (n=61).

Within the United States, on average, participants have obtained an  $M=6.2(SD=2)$  on Allocentrism and an  $M=6.3(SD=2)$  on Idiocentrism (Singelis, et al 1995). Higher scores on each scale indicate stronger self-orientation for that particular dimension. In comparing the Hawaii and Illinois individuals, when comparisons were made of the correlation coefficients, reliability was found given the consistency of alpha variables (Singelis, et al 1995). Items that had been deemed as individualist or collectivist were correlated in positive ways that were consistent with existing literature regarding these constructs. On average, participants were approximately equal in terms of allocentrism and idiocentrism.

According to Triandis et al (1985), in a normative United States sample, allocentrism has been positively correlated with social support in terms of the amount and level of satisfaction with it. Also, allocentrism has been correlated with low levels of alienation and anomie (Triandis, et al, 1985). Conversely, idiocentrism has been positively correlated with achievement and perceived loneliness. According to Triandis and Gelfand (1995), individualism has been correlated with self-reliance,

hedonism, and emotional distance from in-groups (i.e. “I am not to blame if a member of my family fails”). With regard to collectivism, family integrity has been correlated with this construct, such as “Aging parents should live at home with their children until they die;” sociability (“I like to talk to my neighbors every day”); interdependence (“I like to cooperate with others”). Also, there are correlates of collectivism to the subordination of personal goals to in-group goals.

3. *The Shweder and Bourne Egocentrism and Sociocentrism Measure*. This measure was an adaptation of the original scale (Shweder & Bourne, 1982), as modified by Martin LaRoche, Ph.D. (LaRoche & Gualdron, 2006, see Appendix E).

Shweder and Bourne (1982) reported a consensual coding of .95 of the items on the original version of the instrument, concluding that “this in itself suggests a relatively high level of interjudge agreement” (p. 177). The Shweder and Bourne study of 1982 did not reveal information about attempts to establish the validity of their instrument. In fact, no studies have been located in which this measure was used to demonstrate its reliability or validity. However, studying how the Shweder-Bourne relates to the INDCOL was hoped to add to the paucity of psychometric information that currently exists for this measure.

This measure involved participants describing a close acquaintance, offering three descriptive phrases or statements that applied to three friends. There were a set of categories developed to assess the presence of idiocentric or allocentric indicators through *a posteriori* content analyses. They included conceptualizations of sociocentrism and egocentrism (i.e., action vs. traits, context vs. non-contextual).

Each response was coded according to a scoring template provided by Martin LaRoche, Ph.D. Categories for scoring included: action versus trait, social versus individualistic, contextual versus noncontextual, positive versus negative, alone versus together, hierarchical versus non-hierarchical, self-reference versus non-self-reference, and spirituality versus non-spirituality. Responses tended to fall in one of two general categories, of either more concrete or abstract; contextual factors assisted in determining where responses existed.

Given that the information that was reviewed for the purpose of this proposed study has been somewhat limited, the hope was to achieve some "triangulation" between the INDCOL and the Shweder-Bourne measures as they were administered to a sample of rural adults. In this way, it will also be possible to assess the degree to which the two separate measures are consistent.

#### *Data Analysis*

Each of the three research questions for this study used a variety of statistical tests for analysis:

1. *How does a sample of adults from rural Maine compare to the general U.S. population in idiocentrism and allocentrism, as measured by the Individualism-Collectivism measure (INDCOL) and the Shweder-Bourne measure?*

Because the INDCOL and Shweder-Bourne were both continuous measures, this question was intended to be answered through conducting a single-sample t-test to compare the sample means with the instruments' normative data.

2. *What is the relationship between idiocentrism and allocentrism scores on the INDCOL and the idiocentrism and allocentrism scores on the Shweder-Bourne measure?*

To address this question, the allocentrism scale of the INDCOL was correlated to the sociocentrism subscale of the Shweder-Bourne scale, while the idiocentrism scale of the INDCOL was correlated to the egocentrism subscale of the Shweder-Bourne scale. In addition, the INDCOL allocentrism and idiocentrism scales were correlated to the subscales of the Shweder-Bourne scale.

3. *What is the relationship between selected participant characteristics and idiocentrism/allocentrism scores from the INDCOL, and dimensions on the Shweder-Bourne measure of idiocentrism/allocentrism?*

Participant characteristics selected for analysis consisted of: age, education, sex, number of close friends, religiosity, ethnicity, relationship status and number in household. This research question involved the investigation of how INDCOL scores of idiocentrism and allocentrism differed by the various participant characteristics. Pearson correlation coefficients were calculated to assess the relationships on continuously-measured participant characteristics such as age, number in household, number of close friends, and number of new friends. Mean differences were examined for the dichotomously-measured participant characteristics, such as gender, education, relationship status, and degree of closeness, using a t-test for independent samples. For categorical participant characteristics such as religious services and religious type, mean differences on the INDCOL and Shweder-Bourne were examined via a one-way Anova Scheffe post-hoc test. The reason for doing these

analyses was to determine whether there was a relationship between worldview and the stated demographic characteristics.

## Chapter IV

### *Results*

This chapter will provide the results of this study. First, there will be a brief reiteration of the purpose of this study. Secondly, detailed information will be presented, involving measures of egocentrism, sociocentrism, idiocentrism, and allocentrism. Following this, there will be a detailed description of results.

#### *Purpose of Study*

The purpose of this study was to examine a segment of the American rural population, which is under-represented in mental health literature, with regard to the following research questions:

1. How does a sample of adults from rural Maine compare to the general U.S. population in idiocentrism and allocentrism, as measured by the Individualism-Collectivism measure and the Shweder-Bourne measure?
2. What is the relationship between idiocentrism and allocentrism scores on the INDCOL, and the idiocentrism and allocentrism scores on the Shweder-Bourne measure?
3. What is the relationship between selected participant characteristics and idiocentrism/allocentrism scores from the INDCOL, and dimensions on the Shweder-Bourne measure of idiocentrism/allocentrism?

Two instruments were used to assess self-orientation, which included four variables: idiocentrism, allocentrism, egocentrism and sociocentrism. A demographic questionnaire was also used.

#### *Shweder-Bourne Means and Standard Deviations*

Means and standard deviations of Shweder-Bourne scales from this research sample included the following: Sociocentrism, mean of 7.67, standard deviation of 5.30; Egocentrism, mean of 35.61, standard deviation of 7.74. Given that the Shweder-Bourne measure is an adaptation of the original measure, there was no adult normative data available with which to compare this study's rural sample. Instead, the Shweder-Bourne measure was used as a means for indicating the validity of the INDCOL. Additional subscales including Positive/Negative, Spiritual/Nonspiritual, Hierarchical/Nonhierarchical/Neutral were designed to measure those specific constructs, and to allow for comparisons to the egocentric and sociocentric subscales.

#### *Individualism-Collectivism Scale (INDCOL)*

This measure was used to assess levels of allocentrism and idiocentrism of the research participants. Normative comparisons were made with this research sample, in order to ascertain how participants compare on these variables.

*Purpose.* The purpose of using the INDCOL in this study was to provide triangulation with the Shweder-Bourne measure. Results of the INDCOL were compared to the Shweder-Bourne results, as well as the demographic findings, in order to elucidate any relationships of import among this rural research sample.

*Scales.* The INDCOL included two sub-scales, each comprised of 16 questions, one for allocentrism (the individual variable of collectivism) and one for idiocentrism (the individual variable of individualism).

*Scoring.* For this study, the INDCOL was calculated by totaling up scores for two subscales of idiocentrism and allocentrism. Item number 30 (*Some people emphasize winning: I'm not one of them*) was reverse-scored. Means were then established for the constructs of idiocentrism and allocentrism to apply to this study sample.

*INDCOL means and standard deviations.* Means and standard deviations for this research sample's INDCOL included all 32 items of the INDCOL, in order to compare means with normative data. These consist of the following: Allocentrism, mean of 6.32, standard deviation of .76; Idiocentrism, mean of 5.52, standard deviation of .98.

#### *Research Questions*

Three specific research questions for this proposed study guided the data analysis:

*Question 1. How does a sample of adults from rural Maine compare to the general U.S. population in idiocentrism and allocentrism, as measured by the Individualism-Collectivism (INDCOL) measure and the Shweder-Bourne measure?*

The significance of this research question has to do with the primary focus of this study, which was to examine if and how rural American populations are different from other groups. To address this question, the study sample's norms were compared to the norms offered by original research studies that examined these

measures. The goal was to establish whether the differences that were found were statistically significant or not. Given that the normative data provided by the INDCOL is a population norm, in comparing the sample mean to the population mean, a single-sample t-test was administered to accomplish this goal.

*Results.* Overall, this research sample had a lower prevalence of idiocentrism than normative comparisons. Adult normative means for idiocentrism was 6.32 (Singelis et al., 1996). For this study sample, the mean value of idiocentrism was 5.52, a statistically significant difference ( $t=.750$ ;  $df=87$ ;  $p=.000$ ). There was no significant difference between the mean for allocentrism for this sample, 6.32, and the normative mean, 6.20 (Singelis, et al, 1996). These results are presented in Table 1, below.

Table 1. *Mean and standard deviation comparisons of Maine and normative samples*

| Singelis et al (1996)     | Means | Standard deviations | T    | Df | p    |
|---------------------------|-------|---------------------|------|----|------|
| Allocentrism              | 6.20  | 2.0                 |      |    |      |
| Idiocentrism              | 6.32  | 2.0                 |      |    |      |
| Rural Maine sample (2007) | Means | Standard deviations |      |    |      |
| Allocentrism              | 6.32  | .76                 | 1.46 | 87 | .147 |
| Idiocentrism              | 5.52* | .98                 | .750 | 87 | .000 |

\* Significant beyond the .001 level

*Question 2. What is the relationship between idiocentrism and allocentrism scores on the INDCOL, and the idiocentrism and allocentrism scores on the Shweder-Bourne measure?*

To address this question, the allocentrism scale of the INDCOL was correlated to the sociocentrism subscale of the Shweder-Bourne scale, while the idiocentrism

scale of the INDCOL was correlated to the egocentrism subscale of the Shweder-Bourne scale. In addition, the INDCOL allocentrism and idiocentrism scales were correlated to the subscales of the Shweder-Bourne scale.

*Instrument reliability for Shweder-Bourne and INDCOL.* Reliability analyses were conducted to assess whether the Shweder-Bourne and INDCOL instruments had sufficient internal consistency for the kind of analyses required in this and subsequent research questions. To do this, Cronbach's alphas were calculated for the scales of the Shweder-Bourne and the INDCOL.

For the INDCOL, analyses were conducted two different ways. For idiocentrism, when including each of the 16 idiocentric INDCOL subscale, the Cronbach's alpha was .733. When including each of the 16 items of the INDCOL allocentrism subscale, the Cronbach's alpha was .539 for allocentrism. Because this was a less than desirable coefficient alpha (Nunnally, 1993), the reverse-scored item (Item 30) was removed, in order to see if the coefficient would improve. With the omission of this item, the Cronbach's alpha for allocentrism increased to .679. As a result, for analyses involving Questions 2 and 3, Item 30 was omitted to allow for the improved reliability statistic to be used. However, this item was included in Question 1, in order to compare study means to normative means.

For Shweder-Bourne items that made up the egocentric subscale (*Trait, Individualistic, Noncontextual, Alone, and NonSelf-Reference*), Cronbach's alpha was .868. On the sociocentric subscale including *Action, Social, Contextual, Together, and Self-Reference*, the Cronbach's alpha was .720. These statistics were in an acceptable range.

*INDCOL allocentrism-Shweder-Bourne sociocentrism.* The Pearson correlation between allocentrism and sociocentrism was .199 ( $p=.069$ ), not statistically significant. The direction was as expected, but the magnitude was considerably more modest than expected, suggesting that the INDCOL allocentrism and Shweder-Bourne sociocentrism do not measure the same constructs.

*INDCOL idiocentrism-Shweder-Bourne egocentrism.* Idiocentrism and egocentrism had a Pearson correlation of .260 ( $p=.017$ ). While statistically significant, the correlation coefficient was still very modest and suggests that these were only slightly related measures.

*INDCOL idiocentrism-Shweder-Bourne sociocentrism.* The Pearson correlation between idiocentrism and sociocentrism was  $-.244$  ( $p=.025$ ). While this correlation was in the expected inverse direction, again the relationship was very slight, even though significant.

*INDCOL allocentrism-Shweder-Bourne egocentrism.* The Pearson correlation between allocentrism and egocentrism was  $-.273$  ( $p=.012$ ). Similar to above, these were divergent constructs; therefore, as expected, there was an inverse relationship. However, once again, while statistically significant, the correlation coefficient was less strong than would be predicted.

*Shweder-Bourne egocentrism-Shweder-Bourne sociocentrism.* The Pearson correlation between egocentrism and sociocentrism was  $-.613$  ( $p=.000$ ). These were also divergent constructs, as evidenced by a robust inverse relationship, suggesting that Shweder-Bourne sociocentrism and egocentrism measure antithetical aspects of worldview, as intended.

*INDCOL idiocentrism-INDCOL allocentrism.* The Pearson correlation between idiocentrism and allocentrism was  $-.032$  ( $p=.764$ ). This was not a statistically significant relationship. These measures appeared to assess essentially independent aspects of worldview.

*INDCOL scales-Shweder-Bourne subscales.* Table 2 includes relationships between the Shweder-Bourne subscales and the scales of the INDCOL. Relationships were in the expected direction, but much more modest than expected, with correlation coefficients ranging from  $.027$  to  $.329$ . The reason for examining these additional relationships was to examine the possibility of relevant statistical relationships or other findings beyond those strictly involving the worldview constructs of individualism and collectivism.

Idiocentrism of INDCOL was significantly correlated with five of the Shweder-Bourne subscales (see Table 2). These included Action (inverse correlation,  $r=-.277$ ;  $p=.011$ ), Trait (direct correlation,  $r=.269$ ;  $p=.014$ ), Noncontextual (direct correlation,  $r=.237$ ;  $p=.030$ ), Self-Reference (inverse correlation,  $r=-.272$ ;  $p=.012$ ), and NonSelf-Reference (direct correlation,  $r=.279$ ;  $p=.010$ ).

The allocentrism scale of INDCOL included four statistically significant relationships with Shweder-Bourne subscales, with half being significant at the  $.05$  level, and the other half at the  $.01$  level. Direct relationships included the Together ( $r=.233$ ;  $p=.033$ ) and Hierarchical ( $r=.221$ ;  $p=.044$ ) subscales, while inverse relationships consisted of Individualistic ( $r=-.297$ ;  $p=.006$ ) and Alone ( $r=-.329$ ;  $p=.002$ , Table 3).

Table 2. *Relationships between Shweder-Bourne and INDCOL scales*

| Pearson correlations | Shweder-Bourne (SB) | Shweder-Bourne (SB) |
|----------------------|---------------------|---------------------|
|                      | Egocentrism         | Sociocentrism       |
| INDCOL Idiocentrism  | .260*               | -.244*              |
| INDCOL Allocentrism  | -.273*              | .199                |

\*Significant at .05 level

Table 3. Relationships between Shweder-Bourne subscales and INDCOL scales

| Pearson correlations<br>(INDCOL&SB<br>Subscales) | Action   | Trait              | Social                    | Individualistic | Contextual      | Non-<br>Contextual |
|--|----------|--------------------|---------------------------|-----------------|-----------------|--------------------|
| INDCOL   | .-       | .269*              | -.090                     | .151            | -.208           | .237*              |
| Idiocentrism                                     | .277*    |                    |                           |                 |                 |                    |
| INDCOL   | .109     | -.190              | .213                      | -.297**         | .040            | -.151              |
| Allocentrism                                     |          |                    |                           |                 |                 |                    |
| Pearson correlations<br>(INDCOL&SB<br>Subscales) | Positive | Negative           | Together                  | Alone           | Nonhierarchical | Hier-<br>archical  |
| INDCOL   | .072     | .012               | -.027                     | .110            | .029            | .045               |
| Idiocentrism                                     |          |                    |                           |                 |                 |                    |
| INDCOL   | -.077    | -.054              | .233*                     | -               | -.099           | .221*              |
| Allocentrism                                     |          |                    |                           | .329**          |                 |                    |
| Pearson correlations<br>(INDCOL&SB<br>Subscales) | Neutral  | Self-<br>Reference | Non<br>Self-<br>Reference | Spiritual       | Nonspiritual    |                    |
| INDCOL   | .109     | -.272*             | .279*                     | -.132           | .139            |                    |
| Idiocentrism                                     |          |                    |                           |                 |                 |                    |
| INDCOL   | -.179    | .071               | -.154                     | -.146           | -.116           |                    |
| Allocentrism                                     |          |                    |                           |                 |                 |                    |

\*Significant at .05 level

\*\*Significant at .01 level

*Shweder-Bourne subscales.* Correlation coefficients were calculated for the Shweder-Bourne subscales of egocentrism and sociocentrism. For the most part, relationships between and among the subscales were moderate and positive.

For the *egocentric* subscales, intercorrelations ranged from .372 to .743 (Table 4), each significant at the .01 level. The strongest relationship existed between Trait and Noncontextual ( $r=.743$ ;  $p=.000$ ; significant at the .01 level), with Trait and NonSelf-Reference following closely behind ( $r=.731$ ;  $p=.000$ ).

Table 4. *Shweder-Bourne egocentric subscale correlations*

| Pearson Correlations | SB Trait | SB Individualistic | SB Noncontextual | SB Alone | SB NonSelf-Reference |
|----------------------|----------|--------------------|------------------|----------|----------------------|
| SB Trait             | _____    | .547**             | .743**           | .579**   | .731**               |
| SB Individualistic   | .547**   | _____              | .446**           | .646**   | .574**               |
| SB Noncontextual     | .743**   | .446**             | _____            | .456**   | .651**               |
| SB Alone             | .579**   | .646**             | .456**           | _____    | .372**               |
| SB NonSelf-Reference | .731**   | .574**             | .651**           | .372**   | _____                |

\*Significant at .05 level

\*\*Significant at .01 level

For *sociocentric* subscales, correlation coefficients ranged from .027 (non-significant) to .565 (significant at .01 level), having lower levels of correlation overall than the egocentric subscales, indicating that these subscales were less likely to be measuring the same variable. Contextual and Social ( $r=.249$ ;  $p=.023$ ) and Together and Social ( $r=.565$ ;  $p=.000$  significant at .01 level) were significantly related (See

Table 5 for information on sociocentric subscales).

Table 5. *Shweder-Bourne sociocentric subscale correlations*

| Pearson Correlations | SB Action | SB Social | SB Contextual | SB Together | SB Self-Reference |
|----------------------|-----------|-----------|---------------|-------------|-------------------|
| SB Action            | _____     | .362**    | .499**        | .290**      | .514**            |
| SB Social            | .362**    | _____     | .249*         | .565**      | .415**            |
| SB Contextual        | .499**    | .249*     | _____         | .158        | .395**            |
| SB Together          | .290**    | .565**    | .158          | _____       | .027              |
| SB Self-Reference    | .514**    | .415**    | .395**        | .027        | _____             |

\*Significant at .05 level

\*\* Significant at .01 level

Contrary to what was expected, the relationships between the INDCOL and Shweder-Bourne measures were found to be significant but fairly moderate, suggesting that these two instruments are measuring essentially different variables, with little overlap. In order to ensure that the low levels of correlations were not due primarily to outliers or that, alternatively, that there was a curvilinear association, further analyses were completed. Scatterplots were examined for each bivariate association and found no evidence for outliers or a curvilinear association, indicating that the lack of a strong correlation reveals an essential difference between the two measures, in that egocentrism is not the same as idiocentric, nor is sociocentrism the same as allocentric.

This finding led to the question: Would high scores on one instrument be consistently high on the other instrument (and, conversely, would low scores on one instrument be consistently low on the other instrument)? To address this question, cross-tabulations were done. The Shweder-Bourne and INDCOL scales were thus divided into three parts: The bottom 20% of responses were categorized as “low”, the middle 60% were categorized as “middle”, and the top 20% were categorized as “high”.

Given that the Shweder-Bourne and INDCOL were designed to measure similar constructs involving worldview, the expectation would be that scores high or low on one instrument’s construct would correspond with the similar construct of the other instrument. For example, high or low scores of sociocentrism would correspond with high or low scores of allocentrism, while high or low scores of egocentrism would correspond with like-scores of idiocentrism. Instead, respondents who scored high on one measure did not score low on the other, and vice-versa, wherein those who scored low on one measure did not tend to score high on the other measure. For instance, of the 17 respondents who scored high on INDCOL idiocentrism, 10 did not also score high on Shweder-Bourne egocentrism. Additionally, of the 15 respondents who scored low on INDCOL idiocentrism, 10 did not correspondingly score low on Shweder-Bourne egocentrism. Similarly, for the 20 who respond high on INDCOL allocentrism, 15 respondents did not score high on Shweder-Bourne sociocentrism, while for the 14 respondents who scored low on INDCOL allocentrism, 11 of those did not additionally score high on Shweder-Bourne sociocentrism. As a result of the absence of correlations between these

scales and the lack of general consistency in the high-low patterns on the two instruments, these results between the INDCOL and Shweder-Bourne suggest that each scale appears to be measuring different constructs and do not provide cross-validation for each other.

Table 6. *Cross-tabulations between Shweder-Bourne and INDCOL*

| Cross-Tabulations           | INDCOL<br>Idiocentrism<br>Low | INDCOL<br>Idiocentrism<br>High | Total |
|-----------------------------|-------------------------------|--------------------------------|-------|
| SB<br>Egocentrism<br>Low    | 5                             | 1                              | 6     |
| SB<br>Egocentrism<br>Middle | 7                             | 9                              | 16    |
| SB<br>Egocentrism<br>High   | 3                             | 7                              | 10    |
| Total                       | 15                            | 17                             | 32    |

| Cross-Tabulations             | INDCOL<br>Allocentrism<br>Low | INDCOL<br>Allocentrism<br>High | Total |
|-------------------------------|-------------------------------|--------------------------------|-------|
| SB<br>Sociocentrism<br>Low    | 3                             | 3                              | 6     |
| SB<br>Sociocentrism<br>Middle | 10                            | 12                             | 22    |
| SB<br>Sociocentrism<br>High   | 1                             | 5                              | 6     |
| Total                         | 14                            | 20                             | 34    |

To summarize, the relationships between the major scales of the Shweder-Bourne and INDCOL appeared to be weak. Shweder-Bourne egocentrism and

INDCOL idiocentrism were positively and significantly related, but the correlation coefficient was relatively weak. Between Shweder-Bourne sociocentrism and INDCOL allocentrism, there was no statistically significant relationship. Shweder-Bourne egocentrism and INDCOL allocentrism were inversely and significantly related, as were Shweder-Bourne sociocentrism and INDCOL idiocentrism. Overall, the correlations were not very strong (Table 6).

*Question 3. What is the relationship between selected participant characteristics and idiocentrism/allocentrism scores from the INDCOL, and dimensions on the Shweder-Bourne measure of idiocentrism/allocentrism?*

*Gender.* To examine comparisons between gender and Shweder-Bourne and INDCOL scales, an independent sample t-test was conducted (Table 7). The only significant finding was for INDCOL idiocentrism; males had higher scores than females (5.7 to 5.3, etc (t=2.0; df=86; p=.048, at the .05 level).

As discussed above, Oyserman et al., (2002) suggest that men may have higher levels of idiocentrism than allocentrism, as was found in this sample.

Table 7. *Gender t-test* \*Significant at .05 level  
Scale Gender

|                     |        | M    | SD  | T    | df | p     |
|---------------------|--------|------|-----|------|----|-------|
| SB Egocentrism      | Male   | 36.3 | 8.0 |      |    |       |
|                     | Female | 34.5 | 7.5 |      |    |       |
|                     |        |      |     | 0.8  | 82 | .426  |
| SB Sociocentrism    | Male   | 6.9  | 5.0 |      |    |       |
|                     | Female | 8.4  | 5.5 |      |    |       |
|                     |        |      |     | -1.3 | 82 | .203  |
| INDCOL Idiocentrism | Male   | 5.7  | 0.9 |      |    |       |
|                     | Female | 5.3  | 1.0 |      |    |       |
|                     |        |      |     | 2.0  | 86 | .048* |
| INDCOL Allocentrism | Male   | 6.3  | 1.0 |      |    |       |
|                     | Female | 6.6  | 0.8 |      |    |       |
|                     |        |      |     | -1.5 | 86 | .130  |

*Education.* To examine relationships between education levels and Shweder-Bourne and INDCOL scales, an independent samples t-test was conducted. As discussed above, to ensure adequate number of subjects for each group, various demographic variables were collapsed into groups with more reasonable numeric distributions. In this case, the collapsed variables were *high school diploma or less*, and *college degree or more*, reduced from the original six categories of *less Than high school*, *high school diploma*, *undergraduate degree*, *technical college degree*, *master's degree* and *advanced degree*.

There were no statistically significant differences between education levels with regard to Shweder-Bourne egocentrism ( $t=0.5$ ;  $df=82$ ;  $p=.595$ ), Shweder-Bourne sociocentrism ( $t=-1.0$ ;  $df=82$ ;  $p=.923$ ), INDCOL idiocentrism ( $t=1.5$ ;  $df=86$ ;  $p=.137$ ) or INDCOL allocentrism ( $t=1.2$ ;  $df=86$ ;  $p=.244$ ) (Table 8).

Table 8. *Education t-test*

| <i>Scale</i>        | <i>Education</i> |      |     |      |    |      |
|---------------------|------------------|------|-----|------|----|------|
|                     |                  | M    | SD  | T    | df | p    |
| SB Egocentrism      | High School      | 36.0 | 7.8 |      |    |      |
|                     | College Degree   | 35.1 | 7.7 |      |    |      |
| Statistics          |                  |      |     | 0.5  | 82 | .595 |
| SB Sociocentrism    | High School      | 7.6  | 5.1 |      |    |      |
|                     | College Degree   | 7.7  | 5.6 |      |    |      |
| Statistics          |                  |      |     | -1.0 | 82 | .923 |
| INDCOL Idiocentrism | High School      | 5.6  | 0.9 |      |    |      |
|                     | College Degree   | 5.3  | 1.0 |      |    |      |
| Statistics          |                  |      |     | 1.5  | 86 | .137 |
| INDCOL Allocentrism | High School      | 6.5  | 0.9 |      |    |      |
|                     | College Degree   | 6.3  | 0.9 |      |    |      |
| Statistics          |                  |      |     | 1.2  | 86 | .244 |

*Relationship status.* Next, an independent samples t-test was conducted in order to examine comparisons between types of relationship status and Shweder-

Bourne and INDCOL scales. This was another variable in which groups were originally too unequal in their distributions, thus requiring collapsing into fewer groups. In this case, relationship status was collapsed into two discrete groups: *Together* and *Alone*, reduced from six groups: *Married*, *Widowed*, *Legally Separated/Divorced*, *Live with Partner/Unwed*, *Relationship/Live Apart/Unwed*, and *Single, Not in Relationship*.

There were no statistically significant differences between relationship status with regard to Shweder-Bourne sociocentrism ( $t=1.8$ ;  $df=81$ ;  $p=.072$ ), INDCOL idiocentrism ( $t=-.73$ ;  $df=85$ ;  $p=.465$ ), and INDCOL allocentrism ( $t=1.6$ ;  $df=85$ ;  $p=.106$ ). There was one statistically significant relationship between Shweder-Bourne egocentrism and relationship status ( $t=-3.3$ ;  $df=24.7$ ;  $p=.003$ ), where respondents reporting not being in a romantic relationship ( $M=40.1$ ,  $SD=4.0$ ) scored significantly higher than those reporting being in a relationship ( $M=35.0$ ,  $SD=8.0$ , see Table 9). The finding of *relationship status* would be expected, given that there were higher levels of egocentrism for those reporting to be alone, suggesting that people not in relationships are more focused on themselves.

Table 9. *Relationship status t-test*

| <i>Scale</i>        | <i>Relationship Status</i> |      |     |      |      |       |
|---------------------|----------------------------|------|-----|------|------|-------|
|                     |                            | M    | SD  | T    | df   | p     |
| SB Egocentrism      | Together                   | 35.0 | 8.0 |      |      |       |
|                     | Alone                      | 40.1 | 4.0 |      |      |       |
| Statistics          |                            |      |     | -3.3 | 24.7 | .003* |
| SB Sociocentrism    | Together                   | 8.0  | 5.3 |      |      |       |
|                     | Alone                      | 5.0  | 4.0 |      |      |       |
| Statistics          |                            |      |     | 1.8  | 81   | .072  |
| INDCOL Idiocentrism | Together                   | 5.5  | 1.0 |      |      |       |
|                     | Alone                      | 5.7  | .90 |      |      |       |
| Statistics          |                            |      |     | -.73 | 85   | .465  |
| INDCOL Allocentrism | Together                   | 6.5  | 0.9 |      |      |       |
|                     | Alone                      | 6.0  | 1.0 |      |      |       |
| Statistics          |                            |      |     | 1.6  | 85   | .106  |

\*Significant at the .05 level.

*Age.* Pearson correlation coefficients were calculated to assess relationships between age and the Shweder-Bourne and INDCOL scales. There were statistically significant correlation coefficients between age and idiocentrism, egocentrism, and sociocentrism, while no statistically significant correlation coefficients involving allocentrism. The Pearson correlation between idiocentrism and age was .25 ( $p=.021$ ) and was significant at the .05 level. Next, the Pearson correlation between age and egocentrism was a coefficient of  $-.50$  ( $p=.000$ ), while the correlation between age and sociocentrism was  $.30$  ( $p=.006$ ); both were significant at the .01 level.

Older subjects reported higher levels of sociocentrism and lower levels of egocentrism and idiocentrism. In examining Pearson correlations among the four major scales, the relationship between age and egocentrism had the strongest magnitude, with a coefficient of  $-.50$  ( $p=.000$ ). Results involving *age* were expected, as one might expect that as they age, individuals may become more oriented towards others (specifically family), rather than solely themselves. In fact, as respondent age

increases, there was a corresponding increase in number of close friends ( $r=.11$ ).

However, in examining the relationship between age and number in household, there was an inverse relationship, where over time number in household decreased ( $r=-.20$ ).

*Number in household.* There was a statistically significant relationship between number in household and INDCOL allocentrism, with a correlation coefficient of .24 ( $p=.012$ , significant at the .05 level). This was a direct relationship, where respondents reporting larger households had higher levels of allocentrism ( $r=.24$ ;  $p=.012$ ).

*Number of close friends.* No significant relationships were found between respondents' number of close friends, and the scales of INDCOL and Shweder-Bourne.

*Number of new friends.* Pearson correlation coefficients were calculated to establish relationships between respondents' number of new friends and the four major scales of INDCOL and Shweder-Bourne. Among these scales, there was one statistically significant relationship, between number of new friends and Shweder-Bourne sociocentrism, with a correlation coefficient of .28 ( $p=.010$ , significant at the .05 level).

*Degree of closeness.* To analyze comparisons between degree of closeness and scales of INDCOL and Shweder-Bourne, an independent samples t-test was conducted. This variable was collapsed into two categories of *Not Close* and *Close*, reduced from the original four categories of *Not Very Close*, *Sometimes/Not Close*, *More Close Than Not*, and *Very Close*, in order to produce a more even distribution of group numbers (Table 10).

There were no statistically significant differences in degree of closeness involving egocentrism ( $t=1.2$ ;  $df=78$ ;  $p=.244$ ), sociocentrism ( $t=.06$ ;  $df=81$ ;  $p=.951$ ), idiocentrism ( $t=.54$ ;  $df=85$ ;  $p=.588$ ), or allocentrism ( $t=.08$ ;  $df=85$ ;  $p=.940$ ).

Table 10. *Degree of closeness t-test*

| Scale               | Degree of Closeness | Degree of Closeness |     |     |    |      |
|---------------------|---------------------|---------------------|-----|-----|----|------|
|                     |                     | M                   | SD  | T   | df | p    |
| SB Egocentrism      | Not Close           | 36.7                | 6.0 |     |    |      |
|                     | Close               | 34.8                | 8.9 |     |    |      |
| Statistics          |                     |                     |     | 1.2 | 78 | .244 |
| SB Sociocentrism    | Not Close           | 7.6                 | 4.5 |     |    |      |
|                     | Close               | 7.5                 | 5.8 |     |    |      |
| Statistics          |                     |                     |     | .06 | 81 | .951 |
| INDCOL Idiocentrism | Not Close           | 5.6                 | 1.1 |     |    |      |
|                     | Close               | 5.5                 | 0.9 |     |    |      |
| Statistics          |                     |                     |     | .54 | 85 | .588 |
| INDCOL Allocentrism | Not Close           | 6.4                 | 0.9 |     |    |      |
|                     | Close               | 6.4                 | 0.9 |     |    |      |
| Statistics          |                     |                     |     | .08 | 85 | .940 |

*Religious services.* A one-way analysis of variance was conducted to examine whether there were statistically significant differences between attendance at religious services and egocentrism, sociocentrism, idiocentrism, or allocentrism. Originally, groups were broken down into: *Never, Once/Twice a Year, Once a Month, Once a Week, More Than Once Per Week*, to reflect frequency of attendance to religious services. Due to uneven group distributions that would have negatively affected statistical analysis, this variable was collapsed into three groups: *Never, Sometimes* and *Often*. No statistically significant differences were found for sociocentrism, idiocentrism, or allocentrism regarding religious services. Because of this, post-hoc tests were not conducted for any of these variables.

On the other hand, the relationship between egocentrism and religious services was found to be statistically significant ( $p=.036$ , Table 11a). Therefore, a post-hoc analysis was conducted via a multiple comparisons Scheffe, to look at the category compared to other groups. With egocentrism, at least two groups did differ (“never” and “sometimes”) in a statistically significant fashion (Table 11b).

Table 11a. *Religious services analysis of variance*

|                     |                | Sum of Squares | Df | Mean Square | F    | Sig.  |
|---------------------|----------------|----------------|----|-------------|------|-------|
| INDCOL Idiocentrism | Between Groups | 5.21           | 2  | 2.61        | 2.84 | .064  |
|                     | Within Groups  | 76.93          | 84 | .92         |      |       |
|                     | Total          | 82.14          | 86 |             |      |       |
| INDCOL Allocentrism | Between Groups | .26            | 2  | .13         | .16  | .852  |
|                     | Within Groups  | 68.96          | 84 | .82         |      |       |
|                     | Total          | 69.23          | 86 |             |      |       |
| SB Sociocentrism    | Between Groups | 118.59         | 2  | 59.30       | 2.21 | .116  |
|                     | Within Groups  | 2145.79        | 80 | 26.82       |      |       |
|                     | Total          | 2264.39        | 82 |             |      |       |
| SB Egocentrism      | Between Groups | 393.03         | 2  | 196.51      | 3.47 | .036* |
|                     | Within Groups  | 4528.83        | 80 | 56.61       |      |       |

\* Significant at the .05 level

Table 11b. *Religious services analysis of variance post-hoc analysis (SB Egocentrism)*

| Religious services | Religious services | Mean Difference | Sig. |
|--------------------|--------------------|-----------------|------|
| Never              | Sometimes          | 4.9071*         | .042 |
|                    | Often              | 3.8286          | .227 |
| Sometimes          | Never              | -4.9071*        | .042 |
|                    | Often              | -1.0786         | .878 |
| Often              | Never              | -3.8286         | .227 |
|                    | Sometimes          | -1.0786         | .878 |

\*Significant at the .05 level.

*Religious type.* Differences in allocentrism and idiocentrism by religion was examined by way of one-way analysis of variance. This variable included extremely unequal group distributions, thereby necessitating the collapsing into groups that were more similar. The original breakdown consisted of *Baptist, Catholic, Protestant,*

*Christian, Pentecostal, Other, and None.* For statistical analysis, the following four groups were used: *Protestant, Catholic, Other, and None.*

No statistically significant differences were found for egocentrism, sociocentrism, idiocentrism or allocentrism. Because of this post-hoc tests were not conducted (see Table 12).

Table 12. *Religious type analysis of variance*

|                     |                | Sum of Squares | df | Mean Square | F     | Sig. |
|---------------------|----------------|----------------|----|-------------|-------|------|
| INDCOL Idiocentrism | Between Groups | 5.87           | 3  | 1.955       | 2.128 | .103 |
|                     | Within Groups  | 76.27          | 83 | .92         |       |      |
|                     | Total          | 82.14          | 86 |             |       |      |
| INDCOL Allocentrism | Between Groups | 1.21           | 3  | .40         | .49   | .688 |
|                     | Within Groups  | 68.01          | 83 | .82         |       |      |
|                     | Total          | 69.23          | 86 |             |       |      |
| SB Sociocentrism    | Between Groups | 205.63         | 3  | 68.54       | 2.63  | .056 |
|                     | Within Groups  | 2058.75        | 79 | 26.06       |       |      |
|                     | Total          | 2264.39        | 82 |             |       |      |
| SB Egocentrism      | Between Groups | 398.54         | 3  | 132.85      | 2.32  | .082 |
|                     | Within Groups  | 4523.32        | 79 | 57.26       |       |      |

### *Summary*

The primary findings are as follows:

- This sample of rural Maine individuals reported statistically lower levels of idiocentrism than the normative sample, suggesting less self-focus. There were no statistically significant differences in allocentrism.
- In terms of demographic characteristics, the following was found:
  - Males had significantly higher scores of idiocentrism than did females.
  - Those who reported being alone had significantly higher scores on Shweder-Bourne egocentrism than for those reporting to be in a relationship.

- Older participants were significantly higher on Shweder Bourne sociocentrism and significantly lower on Shweder Bourne egocentrism and INDCOL idiocentrism.
- The number of individuals in a household was significantly and positively related to higher levels of allocentrism.
- Higher numbers of new friends reported was associated significantly with higher levels of sociocentrism.
- There was a significant relationship between higher levels of Shweder-Bourne egocentrism with greater frequency of attendance at religious services.

## Chapter V

### *Discussion*

The goal of this research project was to conduct an exploratory study about worldview in a rural Maine population. The results of this research study provide contributions to the correlates of idiocentrism and allocentrism in a rural American population. One implication of research findings in this study is that idiocentrism and allocentrism are to some extent independent constructs, rather than orthogonal ones. Secondly is the finding that overall there was no statistically significant difference found involving allocentrism, but that this sample had lower scores of idiocentrism than normative comparisons. Below is an in-depth discussion about findings from this study, along with implications and suggestions for future research.

#### *Findings*

There was significance found in Individualism-Collectivism Scale (INDCOL) results, while Shweder-Bourne Scale results were not found to be significant. Both individualism and collectivism were evident in this population, when examining various demographic factors. Moreover, lower levels of idiocentrism in this sample offer the possibility that rural areas may be less inclined towards rugged individualism and possibly more willing to be socially interdependent.

#### *Implications*

*Individualism-Collectivism Scale and Shweder-Bourne Scale.* The absence of correlation between INDCOL allocentrism and Shweder-Bourne sociocentrism, and the weak relationship between INDCOL idiocentrism and Shweder-Bourne egocentrism suggests that the INDOL and Shweder-Bourne instruments do not have

nearly as much in common as was expected. It is possible that this sample was unusual or had confounding attributes. However, there are no studies on the intercorrelations of these two measures, so it is not clear whether they show significant interrelationships in other populations.

While the lack of intercorrelation in this study may be caused by a sampling error, there is no evidence to support this. There is also evidence in this study that the nonrandom sample did not contain large amounts of systematic bias. Thus, it is not likely that this sample was confounded in a way that affected the correlations.

Alternatively, either one or both of these measures may not be valid. Given the extensive psychometric analyses from the INDCOL and the relative absence of almost any analyses from the Shweder-Bourne, it is suggested that the Shweder-Bourne may not be a valid instrument. Using the Shweder-Bourne in this study was initially thought of as a way to increase the instrument's empirical validity. The Shweder-Bourne's lack of validity does not, however, discredit the INDCOL, which has an extensive history of use and quantitative refinements from different researchers (Triandis & Gelfand, 1998; Oyserman, Coon, & Kemmelmeier, 2002). The INDCOL has been used with samples of millions of people (Oyserman, 2002), while the Shweder-Bourne is included in only one known study, which was anthropological in nature and with no further revisions.

Based on study results, it is likely that the Shweder-Bourne is not measuring the same worldview constructs as the INDCOL. Although conceptually similar, egocentrism and idiocentrism are not significantly related, just as sociocentrism and allocentrism are not related. To illustrate, the Shweder-Bourne is more effective in

assessing cultures than individuals (Shweder & Bourne, 1982), while the INDCOL was developed to assess individuals within cultures (Hui, 1988).

Moreover, while in name the INDCOL and Shweder-Bourne appear to measure constructs in a similar manner, the methodology is very different. The Shweder-Bourne assesses egocentrism and sociocentrism using a qualitative approach through individual narratives, while the INDCOL assesses idiocentrism and allocentrism via a more quantitative method. For the INDCOL, there are extensive normative data, while this is not the case for the Shweder-Bourne.

*Demographic variables.* Overall, demographic questions that resulted in no significant differences included religion, education, number of close friends and degree of closeness. One exception involved results involving ethnicity. Higher levels of idiocentrism were consistent with the idea that self-reliance is valued more than interdependence. This makes sense in considering the need for independence as a result of geographic disparity and access to fewer options for available community activities and services.

One possible reason for the lack of significant findings among demographic variables involves the study's instrumentation. For example, were questions worded in a particular way to affect answering? Or was this instead related to unique qualities of the research sample? The next section will address limitations of this study based on above considerations.

### *Study Limitations*

*Sampling.* Two areas of potential limitations involve the study sample and the modes of measurement. As discussed above, the majority of this study's sample was

obtained through data collection at Marden's, a local and extremely popular surplus-salvage store in Maine. Marden's is a chain of stores that are spread out throughout the state. One potential limitation of obtaining subjects from this one particular location is that it resulted in a non-random sample.

However, it appears that on the whole, the study sample represented a well-balanced cross-section of rural Maine. Evidence for this is suggested by the study sample's apparent variability. Variability was most prevalent with regard to sex and age, with less variability in areas such as race and ethnicity. Still, such limited variability in race and ethnicity is consistent with the racial/ethnic composition within Maine. Given the sample's good variability, there is support for confidence that worrisome systematic bias is not present. Therefore it appears that Marden's shoppers represent a cross-section of people within the state of Maine.

There was reasonable generalizability of results with regard to demographic variables of the study sample (i.e. percentage of ethnic, age, and gender distributions being similar to the population of Maine at large). However, the process of data collection, via a combination of mailings to local Elks Clubs and solicitation at a local surplus and salvage store, could have unwittingly involved selection bias. Therefore, as mentioned in Chapter IV, attempts were not made to sample the entire population randomly. In this way, solicitation occurred nonsystematically, where "response rate" did not apply.

Another limitation of this study involves the ethnic distribution of the study sample. Survey results yielded a predominance of non-Hispanic white respondents. While this is approximately representative of the population-at-large in the state of

Maine, it limits the generalizability of results from extending to other rural populations in the United States. Therefore, it must be acknowledged that this non-diverse sample is similar to the homogenous culture of northern, rural Maine, while lacking the kind of ethnic diversity that exists in other parts of the country.

*Measurement.* The more likely possibility involves measurement as a limitation. As discussed above, results suggest that there was a lack of agreement between the INDCOL and the Shweder-Bourne. Though it is a measure of egocentrism and sociocentrism, it was not correct to assume, as this researcher initially did, that these constructs correlate with idiocentrism and allocentrism on the INDCOL. This concern was made evident through less than strong relationships between scales of the INDCOL and the Shweder-Bourne measures.

*Validity.* Because of the incongruence of these constructs suggested by the results, it is difficult to draw definitive conclusions involving worldview and this rural sample. While the scoring was good, the lack of normative data in the Shweder-Bourne introduces serious questions about the internal validity because there is no way of comparing study results with normative populations. This absence of correlation suggests that problems with instrumentation may be a significant threat to the internal validity of this study. Still, it is once again important to acknowledge that the INDCOL has valuable normative data.

In terms of the demographic survey of this study, the only form of validity obtained is face validity. This leads to questions about how well the demographic survey measured the complexity of the variables being assessed. One example, as discussed above, involves degree of closeness among friendships, with particular

concern about the construct validity of the item. Another example relates to items in which there were no significant findings, and where more definitive results were expected.

#### *Conclusions and Future Research Considerations*

The current research has made constructive efforts to address the three research questions. With findings supporting the existence of both idiocentrism and allocentrism within this study, it suggests that both individualism and collectivism may be inherent constructs in rural areas (or, at least for this particular rural sample). This allows for a foundation upon which to build future research, and reinforces the complexity and diversity of rural populations, given the duality of these findings.

This research study also indicates the utility for a future, more all-encompassing research study that could involve a comparison of multiple rural parts of the United States. As discussed earlier, in literature, rural areas sometimes are depicted simplistically and in a perspective that does not account for the wide variability of rural areas (Spoth, 1997).

Specific to the study's instrumentation, further psychometric research on the Shweder-Bourne will aid in improving sensitivity in this area. Regardless of this, it is important to note that this study is the first that does provide normative data for the Shweder-Bourne, albeit for a relatively small rural sample. Future research may involve including two measures that more closely measure similar constructs of self-orientation. Moreover, studies to develop a normative sample for the Shweder-Bourne may resolve the issue. Also, research on the validity of both measures may help determine more clearly what is actually being measured.

In conclusion, rural groups in the United States are a significant, essential, and vital segment of the population, and this could be extended to rural populations of all nations. They contribute broad and rich histories and diversities, not unlike ethnic minority groups in all societies of the world. Research findings of this sample suggesting equivalent levels of allocentrism to normative populations support continued interventions that are consistent with the cultural assumptions of this variable. Thus, in accordance with multicultural literature and mental health ethics codes, assessing worldview among rural American populations is an important first step in critically examining mental health interventions among rural populations, with the ultimate goal of maintaining culturally-sensitive treatments and philosophical rationales for these treatment modalities.

## Appendix A: Telephone Script

SP: Hello, I am calling to request your agency's participation in a study examining how rural people view themselves in relation to the world around them. Are you interested in hearing more about this?

*(If yes, then)*

SP: If your agency decides to volunteer to participate, then approximately 20 volunteers from the organization will be asked to complete a packet that includes a series of three questionnaires. The first questionnaire will ask for some demographic information. The second questionnaire will be asked to answer a number of 32 questions about how people view themselves in relation to others and other parts of their lives. The third questionnaire will ask you to describe a person that you know. Anyone over 21 and who has lived in Maine for most of their lives is eligible to participate.

Regarding confidentiality, participation in this study will be anonymous. This means that there is no way for myself or anyone else to identify or connect people to the answers that they provide. In order to aid in this process it will be important for people to not provide any identifying information when responding. Further, any reports, articles or publications based on this research will use only the conclusions of the group as a whole and will not identify any particular person as part of the study.

The potential risk of participating in this study is that people may feel some mild discomfort in answering some of the personal questions. Given this, people who participate may decide to skip any uncomfortable questions. Any information contributing will be useful to my research. The decision to participate in this research

project is up to you. You do not have to participate and you can refuse to answer any questions.

If you agree to participate in this study, I will donate \$100 to your agency as appreciation for people's time and efforts contributing to my research. The benefits of this research can be potentially significant, in being able to continue to study rural American populations with a particular focus on mental health interventions.

Also, if you agree to participate, I'd like to deliver twenty questionnaire packets at a mutually convenient day and time. (*Set up appointment time and place*)

## Appendix B: Unsigned Consent Form

### **Request to Participate in Research**

We are inviting you to take part in a research study. The purpose of this research is to better understand how rural people view themselves in relation to the world around them.

You must be at least 21 years old to participate in this research project. Anyone over 21 years old who has lived in rural Maine for most of their life is a good candidate for this study.

If you decide to take part in this study, we will ask you to fill out a packet with three questionnaires. The first questionnaire will ask you some general questions (for example, questions about how old you are, number of people in your household, etc.). The next questionnaire will ask questions about how you view yourself in relation to other people and other parts of your life, where you will assign numbers to 32 questions. The third questionnaire will ask you to describe a person that you know. It will take about 20-30 minutes.

**The possible risks or discomforts of the study are minimal.** You may feel a little uncomfortable answering personal questions. If this occurs at any point, you always have the option of skipping one or more questions.

**There are no direct benefits to you for participating in the study.** However, your answers will help us to learn more about whether rural Americans are more oriented to individual or group tendencies.

**Your part in this study is anonymous.** This means that no one will know if you took part in this study and no one, including the researcher, will be able to match your answers to the questions with your actual identity. Any reports or publications based on this research will use only group data and will not identify you or any individual as being part of this research project.

**The decision to participate in this research project is up to you.** You do not have to participate and you can refuse to answer any questions.

**If you have any questions about this study,** please feel free to call Stephanie Poplock, 207-745-5338, the person mainly responsible for the research.

**If you have any questions about your rights in this research,** you may contact Vivienne A. Conner, Coordinator, Human Subject Research Protection, Division of Research Integrity, 413 Lake Hall, Northeastern University, Boston, MA 02215, telephone: 617-373-7570.

You may keep this form for yourself.

Thank you,

Stephanie Poplock, M.S.W.

## Appendix C: Demographic Questionnaire

- 1) What level of education do you hold?
  - 1- Less than high school degree
  - 2- High school degree
  - 3- Undergraduate college degree
  - 4- Technical college degree
  - 5- Bachelor's degree
  - 6- Master's degree
  - 7- Advanced graduate degree
- 2) How old are you? \_\_\_\_\_
- 3) *Check:* \_\_\_\_ Male \_\_\_\_ Female
- 4) How would you categorize your racial/ethnic/cultural background?
  - 1-Non-Hispanic White
  - 2- Hispanic or Latino American
  - 3- African American
  - 4- American Indian or Alaskan Native
  - 5- Asian American or Pacific Islander
  - 6- Other \_\_\_\_\_
  - 7- French descent
- 5) How many people live in your household? \_\_\_\_\_

6) Which best describes your current relationship status?

- 1- Married
- 2- Widowed
- 3- Legally separated/divorced
- 4- Living with partner, unmarried
- 5- In a relationship, living apart and not currently married

7) a. How many close friends have you had in the past 12 months? \_\_\_\_

b: How many new friends have you made in the past 12 months? \_\_\_\_

c: What degree of closeness have you had with friends on average in the past 12 months?

- 1- not very close
- 2- sometimes close, sometimes not
- 3- more close than not
- 4- very close

8) a. Do you attend religious services on a regular basis?

- 1- Never
- 2- Once or twice a year
- 3- Once a month
- 4- Once a week
- 5- More than once a week

b. If you identify with a certain religion or spirituality, please name it here: \_\_\_\_\_

## Appendix D: Individualism- Collectivism Scale

Strongly disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

- \_\_\_ 1. I prefer to be direct and forthright when discussing with people.
- \_\_\_ 2. My happiness depends very much on the happiness of those around me.
- \_\_\_ 3. I would do what would please my family, even if I detested that activity.
- \_\_\_ 4. Winning is everything.
- \_\_\_ 5. One should live ones life independently of others.
- \_\_\_ 6. What happens to me is my own doing.
- \_\_\_ 7. I usually sacrifice my self-interest for the benefit of my group.
- \_\_\_ 8. It annoys me when other people perform better than I do.
- \_\_\_ 9. It is important for me to maintain harmony within my group.
- \_\_\_ 10. It is important for me that I do my job better than others.
- \_\_\_ 11. I like sharing little things with my neighbors.
- \_\_\_ 12. I enjoy working in situations involving competition with others.
- \_\_\_ 13. We should keep our aging parents with us at home.
- \_\_\_ 14. The well-being of my co-workers is important to me.
- \_\_\_ 15. I enjoy being unique and different from others in many ways.
- \_\_\_ 16. If a relative were in financial difficulty, I would help with my means.
- \_\_\_ 17. Children should feel honored if their parent receive a distinguished award.
- \_\_\_ 18. I often “do my own thing”.
- \_\_\_ 19. Competition is the law of nature.
- \_\_\_ 20. If a co-worker gets a prize I would feel proud.
- \_\_\_ 21. I am a unique individual.

- \_\_\_22. To me, pleasure is spending time with others.
- \_\_\_23. What another person does better than I do, I get tense and aroused.
- \_\_\_24. I would sacrifice an activity that I enjoy very much if my family did not approve of it.
- \_\_\_25. I like my privacy.
- \_\_\_26. Without competition it is not possible to have a good society.
- \_\_\_27. Children should be taught to place duty before pleasure.
- \_\_\_28. I feel good when I cooperate with others in my group.
- \_\_\_29. I hate to disagree with my group.
- \_\_\_30. Some people emphasize winning: I'm not one of them.
- \_\_\_31. Before taking a major trip, I consult with most members of my family and many friends.
- \_\_\_32. When I succeed, it is usually because of my abilities.

Appendix E: Shweder & Bourne Egocentrism and Sociocentrism Measure

(adapted version)

Instructions:

Please think of three close friends and write three descriptive phrases for each person, for a total of nine phrases.

## Appendix F: Shweder &amp; Bourne Egocentrism and Sociocentrism Measure Scoring

## Template (adapted version)

Instructions to *respondents*: “Please write three phrases for each of three close friends.”

Instructions to *researcher*: "On each card you will find a phrase that was used to describe a person. Please consider each phrase carefully and apply to it each of the four sets of instructions provided below. The instructions themselves explain how to use letter-abbreviations (P, T, A, etc.) in coding the phrases. In most cases a phrase will be categorized in accord with more than one of the four sets of instructions. If a phrase is in negative form, employing negations such as "is not", "does not", "has not", "would not", etc. (or contractions of these), treat it as though it were in its positive form. It may help to say to yourself the positive form of the phrase" (Shweder, 1981).

**The interview**

All participants are asked to describe three different people, not physically but how they are as a person. Often ratees will be surprised and the evaluator can state “not to describe the person physically but how they are as a person in any way that you want.” Interviewers should not give an example; they should repeat the same instructions. The description of each person is written word by word. A coding system was developed to enable judges to decide the presence or absence of a number of features related to analyses of the self-construals. Each of the three descriptions of a person is analyzed with the following eight categories. Each category is scored independently of the others. If a response has many phrases (e.g., combinations of

participant's verbs) it is categorized by either the strongest or the most prevalent number of phrases, unless otherwise stated explicitly within the category.

### **Scoring system**

Categories that are scored as 2 are reflective of an allocentric/sociocentric self-construal while categories scored as 1 are reflective of an idiocentric/egocentric self-orientation. Categories that are not scored are not clearly indicative of any of these self-construals but of other possible characteristics. If within the description of a person both categories it is scored as 1.5. A common allocentrism/idiocentrism scale is construed by adding up both scores. Higher scores are more indicative of allocentrism/sociocentrism, while lower scores are more indicative of idiocentrism/egocentrism.

**A) Action versus Trait.** Action terms entail a behavior of the described person. A good indicator of an action term is an active verb for example "she works hard." Note mental acts (e.g., thinks, believes, imagines, wonders) are included as actions. A trait is a state of being or an adjective that describes a person. Traits describe the person in terms of personality traits, that is an adjective (including verbs ending in -ed or ing) which describe personality characteristics. Traits entail an abstraction of an attribute ex. "she is a hard worker", and includes comments that includes "likes" for example "he likes to be with friends" because it is assuming characteristics within the individual, while an action would be "he goes out with his friends." In addition, trait terms include comments like wishes or desires or displays specific traits (e.g., he is very compassionate person).

Within complex sentences stereotypical general responses such as “she is a good person” or “she is nice” are disregarded. Furthermore, if it is a complex sentence in which the ratee is also being included as part of the sentence that is assessed, this self-reflection will not be considered. The described person and not the phrase employed to talk about the ratee her/himself is assessed as a trait or action. For example consider the following sentence “I am happy when my friends are telling jokes.” The part “when my friend are telling jokes” is categorized as an action because the question is to describe others not yourself (“I am happy when”). If a comment has more than one sentence you right down one trait or action for each sentence which ever is more prevalent Trait=T (scored as 1). Action=A (scored as 2) If both are evenly prevalent it is scored as 1.5.

B) Action and Traits can be both be a **Social or Individualistic** attribute, for example “she is friendly” would be a social attribute, while a phrase like “she is an intelligent person” is an individualistic response. The point of this assessment is to categorize traits or actions as social or individualistic. If the action or trait connote clearly an activity that needs to be conducted with others it is scored as social for example “he likes to talk.” In contrast, it is scored as individualistic if the trait or action is performed alone, for example “he gets sad.” Given the level of explicitness of the adjective or verb it will be scored as individualistic or social. If a comment has more than one sentence you categorized the trait or action as either individualistic or social for each sentence which ever is more prevalent or frequent. Individualistic=I (scored as 1) and Social=S (scored as 2) . If both are evenly prevalent it is scored as 1.5.

C) **Contextual versus Non Contextual** qualifier. It is categorized as contextual if any statements of the conditions in which the attributes occur are noted. In addition to describing a person it specifies that the description is true under a particular condition or circumstance. A reasonable indication of the presence of a contextual qualifier can be obtained by asking whether the phrase says that the person is, has, or does something under some particular set of circumstances. Some of the three more common contextual indicators are: 1) Locale 2) Temporal, 3) Situational. The locale qualifier often indicates where or in what place he/she displays the action or trait for example “in Puerto Rico she was very happy” or “in his house he seems happier.” The temporal qualifier may indicate the frequency of the action/trait in terms of adverbs such as often, sometimes, always or secondly when or at what times does the trait/action occur “at two he is always at work.” Situational contextual indicators describe a specific situation in which the action or trait occur does not specify the time or place such as “when she gets angry she is horrible.” A non contextual qualifier involves a statement that does not describe the context for example “he works hard”. Non-contextual=NC (scored as 1) and Contextual=C (Scored as 2). If only one indicators of contextual appears it is scored as Contextual rather than non al.

D) **Positive or Negative:** The overall question is negative or positive. Positive=P and Negative =N.

E) **Alone or together:** Alone is statement that involves just one individual within the rates description of the person for example “He likes to study” and together involves explicitly more than one person “he likes to study with others” or “ Mike likes Mary.” In contrast, to alone descriptors such as “he studies a lot” or “he is nice” which only

involve one individual within the person. If the sentence is a self reference (see below on G) it is categorized as alone. This keeps the self-reference category independent from this alone/together category. If the noun “we” or “us” is employed it is scored as together. If a relationship is described (e.g., he is my brother) it is categorized as alone because it only involves one person and secondly as means to keep this category independent from the contextual category. If any of the descriptors sentences has two people it is scored as to Alone=AL (scored as 1) and Together=TO (scored as 2)

F) **A Hierarchical position or Non-Hierarchical.** Example a hierarchical one would be “he is my boss” and an egalitarian one would “he is my coworker”. Neutral would not entail any hierarchical order. Hierarchical=H Non Hierarchical=NH Neutral=NT

G) **Self-reference vs. Non-Self-reference.** Makes reference to the person rating in one way or the other for example, “She loves me very much” or “she is my wife.” “my son”. No self-reference=NS (scored as 1) Self-reference=SR (Scored as 2)

H) **Spirituality vs. Non Spirituality** refers to the presence or not of any indications of a religious or spiritual being, for example “God” “Angel”. Spiritual is coded as SP and non spiritual is coded as NSP.

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