



The Role of Culture in Affective Empathy: Cultural and Bicultural Differences

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Abstract

Empathy is essential for healthy relationships and overall well-being. Affective empathy is the emotional response to others' distress and can take two forms: personal distress or empathic concern. In Western cultures, high empathic concern and low personal distress have been implicated in increased prosocial behaviour (e.g., Eisenberg et al., 1989) and better emotion management and peer relations (e.g., Eisenberg and Fabes, 1998). Various factors have been examined with respect to affective empathy, but the role of culture has received little attention. Previous work suggests that children from East Asian cultures compared to those from Western cultures experience greater personal distress and less empathic concern (e.g., Trommsdorff, 1995), but no work has specifically examined these differences in adolescents or individuals who identify as 'bicultural'. The current research examines cultural differences in affective empathy using the Interpersonal Reactivity Index (Davis, 1980) in an adolescent and young adult sample ($n=190$) and examines how empathy relates to social-emotional health in bicultural individuals. Consistent with research on children, East Asian adolescents reported greater personal distress and less empathic concern than their Western counterparts. The bicultural individuals' scores fell in between the East Asian and Western groups, but revealed significant differences from their 'uni-cultural' peers, demonstrating shared influences of community and family. Importantly, however, the relationship between affective empathy and social-emotional health in bicultural individuals was the same as for Western individuals. The current results provide an important first step in understanding the different cultural influences on empathic responding in a previously understudied population – bicultural individuals.

Keywords

Culture, bicultural, empathy, prosocial behavior, affective empathy, personal distress, empathic concern

Empathy plays a vital role in one's social-emotional health and well-being. The ability to perceive what other people are feeling and appropriately share that emotional state enables us to react properly to social situations. Higher levels of trait empathy predict positive outcomes, such as better emotion

management and relationships with peers, and even leads to a heightened valuation of others' welfare and well-being (e.g., Eisenberg et al., 1991; Batson et al., 1995; Eisenberg and Fabes, 1998). However, the majority of this work has been done in Western cultures and there is little work outlining potential cultural differences, both cross-culturally and for those individuals who are 'bicultural' – that is, individuals who are a part of two distinct cultures, usually by birth place and heritage. The current research examines cultural differences in affective components of empathy in an adolescent and young adult sample and assesses the relationship between social-emotional health and empathy in a bicultural group of adolescents.

The concept of 'empathy' is multifaceted, with distinct components that influence empathic responding, but which are difficult to quantify for many researchers (e.g., Choplan et al., 1985; Duan and Hill, 1996). Historically, there has been much debate over the conceptualization and operationalization of empathy (Duan and Hill, 1996; Preston and deWaal, 2002), and although there are still various conceptualizations in the current literature, many (if not most) researchers agree that it is valuable to characterize empathy as consisting of two distinct, but interrelated, components: cognitive and affective. Cognitive empathy refers to one's ability to recognize and identify another person's feelings (e.g., Davis, 1980; Hoffman, 1977). This is distinct from the affective component in that it focuses exclusively on the cognitive processes and ignores the emotional reactions to others' feelings.

Affective empathy, the component of interest herein, refers to one's emotional responses to another person's emotion or situation (e.g., Feshbach, 1975; Hoffman, 1977; Eisenberg and Miller, 1987). This does not necessarily require that one feel the same as the other individual, but rather that one's own emotions are more in line with the other person's situation than one's own (Hoffman, 2000). Typically, this involves experiencing emotions that are similar to those of the other person, but at times, affective empathy can manifest in different emotions. For example, if Katie bullies Jennifer, Jennifer may feel fearful. If Anna witnesses the bullying and feels angry, she is displaying affective empathy; although her anger is different from Jennifer's fear, it is more in line with Jennifer's situation than her own.

Further distinctions are made within affective empathy. Specifically, there are two possible types of affective empathic responses that one may experience upon witnessing and recognizing another person's distress: personal distress or empathic concern (e.g., Davis, 1980; Eisenberg and Fabes, 1990). Personal distress is defined as the experiencing of negative emotions as a result of another person's distress and specifically involves individuals turning their focus inward (i.e., focusing their attention on their own emotions),

thus removing their attention from the person in distress (Schroeder et al., 1988; Eisenberg et al., 1989, 1998b). In contrast, empathic concern is usually understood as experiencing feelings of concern for the other individual. It has an 'other-focus' quality, namely a focus towards the situation of the other person. As such, the correlates of each of these affective subcomponents are quite different, at least in Western cultures. Personal distress tends not to predict helping behaviour or other prosocial acts aimed at alleviating the discomfort of the other individual, but instead, is believed to involve a self-focused attempt to relieve the anxiety produced by the negative feelings brought about by experiencing someone else's distress. On the other hand, empathic concern is predictive of prosocial behaviour such as altruistic helping, or at least attempting to help alleviate the other's distress (Mehrabian and Epstein, 1972; Davis, 1983a,b; Eisenberg and Miller, 1987).

The importance of empathy, and one reason it has captured the attention of many researchers, lies in its ability to predict various outcomes in Western culture. As previously mentioned, higher levels of empathy predict better emotion management and better relationships with peers (Eisenberg et al., 1991; Batson et al., 1995; Eisenberg and Fabes, 1998), and can also facilitate prosocial behaviour (Eisenberg et al., 1989). More broadly, higher levels of empathy have been implicated in better overall social-emotional health in individuals. Social-emotional health is a broad construct that encompasses many different domains of functioning. It includes, but is not limited to, the interpersonal (e.g., expressing affection toward others) and intrapersonal (e.g., regulating one's own emotions and behaviour) elements of affective well-being, as well as the quality of one's social relationships. The ways in which the unique aspects of empathy predict social-emotional health are diverse. For instance, displays of empathic concern in response to a less fortunate target have been found to contribute to positive emotional functioning, as indicated by lower levels of loneliness, but are also positively correlated with shyness, emotional vulnerability, emotional reactivity, and chronic fearfulness (Davis, 1983c). Other research suggests that affective empathy may exert a beneficial influence on social-emotional functioning by improving conflict management and decreasing conflict engagement (de Wied et al., 2007) and by increasing prosocial giving or helping (Davis, 1983b; Eisenberg et al., 1989). The profound influence of empathy on elements of daily life provides the impetus to further examine the factors that may affect individual differences in empathic responding.

There are several known factors that influence components of empathy or empathic reactions, such as the ability to regulate one's emotions (for a review, see Eisenberg, 2000), levels of compassion (Batson et al., 2005), and

perceived similarity to the other individual (e.g., Batson et al., 2005; Eklund et al., 2009). However, another important factor that has received far less attention is culture (but see Trommsdorff, 1995; Friedlmeier and Trommsdorff, 1999; Trommsdorff et al., 2007). Trommsdorff and colleagues (2007) examined various behavioural empathic responses to another's distress in four countries (two Western and two South East Asian) and found that preschool children from South East Asian cultures displayed more personal distress and fewer instances of empathic helping behaviour relative to children from Western cultures. These results suggest inherent differences across cultures in empathic responding. Despite these initial findings with children, many questions remain about the role of culture and cultural identity in empathic responding.

One question that remains is whether the same relationship between empathy and culture holds in an adolescent population. The aforementioned work demonstrating cultural differences was performed exclusively with young children and, thus, it is of interest whether or not the relationships found remain the same over development. It has been suggested that at least one mechanism behind these cultural differences stems from differences in parenting styles (Friedlmeier and Trommsdorff, 1999). That is, the transmission of empathic behaviour comes from parent-child interactions whereby the parent serves as the 'regulator' of emotions in the child's emotional response. In Friedlmeier and Trommsdorff's (1999) study, toddlers experienced the distress of a playmate and the maternal response to their children was recorded along with the toddler's emotional response across two cultures – German and Japanese. The authors found that while mothers in both cultures responded contingently to their children's distress and both showed sensitivity to the child, the pattern of behaviours between the mother and child were different. German dyads showed more positive emotion regulation compared to Japanese dyads who showed more negative emotion regulation (i.e., regulation by avoiding the source of distress). These differences have implications for empathic responsiveness, as positive emotion regulation has been linked to other-focused empathic behaviour and negative emotion regulation linked to self-focused behaviours (for a review, see Eisenberg, 2000). While it is possible that these early relationships continue to hold across development, it is also possible that as children age, other factors (e.g., changes in peer relations, increased exposure to the broader cultural community) may affect their empathic responding, altering the manner in which they respond to others in distress. Research into these cultural differences in somewhat older samples than previously tested (e.g., adolescence and young adults) is needed to determine if the differences found in childhood remain or if other factors intervene to change them.

A second question is what types of affective empathic behaviours are present in individuals identified as 'bicultural' (i.e., those who simultaneously belong to two cultures through their heritage, on the one hand, and their place of residence, on the other). In light of the increasing cultural diversity in today's societies and the potentially important role cultural identity plays in empathic behaviour, there is a pressing need for research examining these constructs in those who identify as bicultural. Is the construct of empathy in bicultural individuals influenced more heavily by one of the two cultures they identify with than the other? Or, is empathy in bicultural individuals reflective of an amalgamation, or blending, of the two comprising cultures? Furthermore, does the relationship between empathy and social-emotional health found in Western samples (e.g., Kinnunen and Pulkkinen, 2003) hold in a bicultural group living in a Western culture? That is, empathy predicts elements of social-emotional health (e.g., De Wied et al., 2007) and better social-emotional health predicts academic and social success in Western cultures (e.g., Kinnunen and Pulkkinen, 2003; Márquez et al., 2006), yet what this relationship looks like in those who are living in a Western culture but also identify with a different culture (e.g., Asian) remains an open question.

To address these questions, we administered the Interpersonal Reactivity Index (IRI) (Davis, 1980) as a measure of the affective components of trait empathy and the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) as a measure of social-emotional health to students living in Vancouver, British Columbia, Canada. Vancouver is a culturally diverse city with a high prevalence of Asian citizens, Caucasian citizens and Asian immigrants, making it an excellent locale for examination of the aforementioned research questions. Given the non-existence of research on empathy and social-emotional health in this bicultural population, it is difficult to make specific a priori hypotheses about how and whether empathy and social-emotional health may differ in this bicultural sample. Thus, exploratory research is not only warranted but vitally needed to provide the foundations for further research in this area.

In short, the current research had three main goals. The first goal was to examine components of affective empathy in those who identify as 'Western' versus those who identify as 'Asian'. The second was to determine whether or not empathy in individuals who identify as 'bicultural' differs systematically from individuals in one or both of the two cultural groups with whom they identify. The third primary objective was to assess whether, and how, empathy relates to social-emotional health in those identifying with both Western and Asian cultural groups (i.e., the bicultural group).

Methods

Participants

A total of 190 high school and university undergraduate students from the Vancouver area took part in the study (69 high school; 121 university; mean age=19.31 years, SD=2.64 years). The sample was predominantly female (high school sample: 58 female, 5 failed to report gender; university sample: 96 female, 1 failed to report gender). Informed consent was obtained from all participants, either by the participant or in the case of underage participants (i.e., those under 18 years of age), parental consent was obtained. Participants were given either a gift certificate to a local movie theatre (high school sample) or received course credit (university sample) for their participation. An additional 52 participants were run but excluded due to their ethnicity (15; all outside the target groups of interest), a failure to report ethnic information (place of birth or self-identified ethnicity) (24), failure to complete the questionnaires (4), and a lack of proficiency in English (9).

Measures

The Interpersonal Reactivity Index (IRI) (Davis, 1980). This 28-item index is used to assess both cognitive and affective components of dispositional empathy. Questions are on a 5-point Likert type scale, with answers ranging from ‘does not describe me well’ to ‘describes me very well’. It is one of the most widely used self-report measures of empathy in circulation and has both good internal and external validity (Davis, 1980, 1983c). The IRI provides scores on four different components of empathy:

1. Personal distress: the tendency to experience distress and/or discomfort when witnessing another person’s distress (e.g., “Being in a tense emotional situation scares me.”).
2. Empathic concern: the tendency to feel sympathy and/or concern for others in negative situations (e.g., “I often have tender, concerned feelings for people less fortunate than me.”).
3. Fantasy: the frequency with which one places oneself into fictional situations (e.g., “After seeing a play or a movie, I have felt as though I were one of the characters.”).
4. Perspective-taking: the ability to take the psychological point of view of another person (e.g., “I sometimes find it difficult to see things from the ‘other guys’ perspective.” (reverse-coded)).

Only the first two components were of interest in the current analyses as they represent the affective facets of empathic responding, although answers for all four subscales were obtained. In the current sample, the measure demonstrated good internal validity with all alphas greater than 0.70 with only 7 items per scale. As alpha is dependent upon sample size, we also calculated internal reliability using the Spearman-Brown prophecy formula for 20 items; with this, all subscales show very good internal reliability of 0.87 and higher.

Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). This questionnaire consists of 25 items on a 3-point scale with answers ‘not true’, ‘somewhat true’, and ‘certainly true’. The questionnaire provides scores on five different components of social-emotional health:

1. Emotional symptoms (e.g., I am often unhappy, depressed, or tearful)
2. Conduct problems (e.g., I usually do as I am told (reverse coded))
3. Hyperactivity/Impulsivity (e.g., I am constantly fidgeting or squirming)
4. Peer relationship problems (e.g., I would rather be alone than with people my own age)
5. Prosocial behaviour (e.g., I try to be nice to other people. I care about their feelings)

The SDQ was administered only to the high school sample because it has not been validated for university-aged students. It was initially validated on high school students up to age 16 but has more recently been used in older adolescents (Van Roy et al., 2008; Cooke and Jones, 2009). Moreover, in our high school sample there were no mean differences by age on any of the five subscales and there was adequate reliability for all subscales (ranging from 0.79 to 0.91 using the Spearman–Brown prophecy formula for 20 items).

Demographics. Participants were asked to indicate their birthday, gender, and answer two questions regarding their ethnic identity and country of origin: (1) What ethnicity do you identify with? and (2) What is your country of birth? Based on their answers to these two questions, we separated them into three categories of cultural groups: Western ($n=32$; 29 university), East Asian ($n=74$; 56 university), and Bicultural ($n=84$; 36 university). Individuals born in and identifying with the same culture were coded as such. Bicultural individuals reported being born in a Western country (e.g., Canada), but identified with an East Asian ethnicity (e.g., Chinese). There were no cases where individuals were born in an East Asian country and identified with a Western ethnicity.

Procedure

Students completed all questions either online (121; university sample) or in paper format (69; high school sample). For all high school participants, the IRI was completed first followed by the SDQ and finally the demographics questions. For all university participants, the IRI was completed first followed by the demographics questions.

Results

Preliminary Analyses

Given evidence that females tend to report higher levels of empathy than males (Eisenberg and Lennon, 1983), we conducted preliminary comparisons of the IRI components by gender. In line with previous research, females rated themselves higher on both of the subscales of interest on the IRI: Empathic Concern and Personal Distress (Table 1). Thus, gender was included as a factor for all future analyses. No effect of age was found.

Culture and Empathy

Multiple ANOVAs were performed with the subscales of the IRI as dependent variables and culture group (Western, Bicultural, East Asian) and gender as the fixed factors. There was a main effect of culture for the Personal Distress subscale, $F_{(2,175)}=7.531$, $P=0.001$, but not for the Empathic Concern subscale. Further examination of the pairwise comparisons showed that Western participants scored the lowest on Personal Distress and this was significantly different from both the bicultural group and the East Asian group. See Table 2 for full results. The bicultural and East Asian groups did not significantly differ from each other although the bicultural group's score ($M=13.36$) fell in between the Western ($M=10.13$) and East Asian ($M=14.08$) means.

As previous research found differences in children on empathic behaviour (Friedlmeier and Trommsdorff, 1999; Trommsdorff et al., 2007), which is most comparable to the Empathic Concern subscale, we also performed pairwise comparisons on the Empathic Concern subscale. In line with this earlier work, there was a significant difference between the Western and East Asian groups' scores, with the Western group showing higher scores ($M=19.53$) for Empathic Concern than the East Asian group ($M=17.38$). However, the bicultural group ($M=18.32$) was not significantly different from either the Western or the East Asian groups.

Table 1
IRI affective subscales by gender

Subscale	<i>n</i>	Males	Females	<i>t</i> -test	<i>P</i> -value
Empathic concern	184	16.93	19.52	3.32	0.001
Personal distress	183	11.63	14.28	3.16	0.002

The *n* values vary because of partially missing data for one female on the Personal Distress subscale of the IRI.

Table 2
IRI subscales by cultural group

Subscale	Western	Bicultural	Asian
Empathic concern	19.533*	18.316	17.378*
Personal distress	10.136****	13.362**	14.089***

* These two variables are significantly different at $\alpha=0.05$; **** these two variables are significantly different from each other at $\alpha=0.01$.

Together, these results suggest there is a Western-East Asian difference in the experience of personal distress and empathic concern, mirroring previous results found in children using behavioural techniques (e.g., Trommsdorff et al., 2007). Of particular interest are the findings that bicultural individuals who bridge these two cultures show a distinct pattern of affective empathy which is in some ways similar to, and in other ways different from, the cultural groups with whom they identify. That is, bicultural individuals' self-reported levels of Personal Distress were higher than those in the Western sample and more in line with their East Asian counterparts. In contrast, bicultural individuals' self-reported levels of Empathic Concern were not significantly different from either of the groups they identify with (despite those two groups being different from each other).

Predicting Social-Emotional Health

We examined how affective empathy related to social-emotional health and well-being for the bicultural group only (due to the small sample sizes for the other two groups in the high school sample). This was particularly important in light of the distinct pattern of affective empathy in this group. To assess this, we used hierarchical multiple regression with the SDQ subscales as dependent variables for a total of five analyses. Age and gender were not

Table 3
Regression equations predicting social-emotional health from affective components of empathy

Dependent	Model R^2	Model F	β (EC)	β (PD)
Emotional symptoms	0.162*	4.063	-0.098	0.431**
Conduct problems	0.003	0.065	0.023	0.042
Hyperactivity/Inattention	0.012	0.263	-0.088	0.111
Peer relationship problems	0.171*	4.320	-0.405*	0.339*
Prosocial behaviour	0.163*	4.082	0.418**	-0.040

* $\alpha=0.05$; ** $\alpha=0.01$.

included as they were unrelated to the SDQ subscales. Given the significant relationship between gender and both Empathic Concern and Personal Distress, gender was partialled out of these variables prior to their entry in the regression equation as predictors. See Table 3 for full results.

Of the five social-emotional health components examined, three were significantly predicted by scores on affective empathy. First, affective empathy accounted for a significant proportion of the variability in Emotional Symptoms, $R^2=0.162$, $P=0.024$, with Personal Distress acting as a significant, unique contributor, $\beta=0.431$, $P=0.008$. Second, Prosocial Behaviour was also significantly predicted by affective empathy, $R^2=0.163$, $P=0.024$. In this case, Empathic Concern was the significant, unique predictor, $\beta=0.418$, $P=0.009$. Finally, affective empathy significantly predicted Peer Relationship Problems, $R^2=0.171$, $P=0.020$. Both Personal Distress and Empathic Concern were significant predictors with the standardized regression coefficients in the expected direction: Empathic Concern negatively predicted these problems, $\beta=-0.405$, $P=0.011$, while Personal Distress positively predicted them, $\beta=0.339$, $P=0.032$.

Discussion

The current research had three main goals: First, to extend findings from the child literature of empathic differences between Western and East Asian cultures in an adolescent and young adult sample; second, to identify whether or not individuals who are bicultural differ systematically from one or both of the aforementioned cultures with respect to empathic responding; and third, to investigate whether and how empathic behaviours predict social-emotional health in a bicultural sample born in a Western country.

With respect to our first goal, we found that adolescents and young adults differ systematically on empathic responding by culture, in line with previous studies looking at empathy differences in young children (e.g., Trommsdorff, 1995). Our Western sample reported greater levels of Empathic Concern and less Personal Distress when confronted with another person's negative emotional state, relative to our East Asian sample. The higher levels of Empathic Concern and lower levels of Personal Distress in the Western group suggest a more 'other-oriented' emotional response to another's distress. These 'other-orienting' emotions are related to greater levels of prosocial and helping behaviours in Western culture (e.g., Underwood and Moore, 1982; Eisenberg and Miller, 1987; Findlay et al., 2006). Moreover, greater levels of these behaviours are also linked to better social and emotional health outcomes (e.g., de Wied et al., 2007; Haughen et al., 2008). With many East Asian individuals immigrating to Western cultures later in life, considerations of these differences may be vital for understanding the process of integration and enculturation into Western societies (a subject we return to in the 'Implications' section).

Second, we explored the empathic responding of individuals who straddle Western and East Asian cultures. Our bicultural sample consisted of individuals who were born and raised in Canada, but were of East Asian ethnicity and self-identified with both cultures. We found a distinct pattern of empathic responding for these bicultural individuals relative to the Western and East Asian groups. For both Empathic Concern and Personal Distress, the bicultural individuals' scores were in between those of the Western and East Asian groups, but the pattern of responding was overall more similar to that of the East Asians. Specifically, the bicultural group was no different from either the Western or East Asian groups for Empathic Concern, but was significantly different from the Western group (and not the East Asian group) with respect to Personal Distress. One possibility for the lack of group differences between the bicultural and Western group on Empathic Concern is that there are multiple processes or mechanisms (e.g., family and peer socialization) at work for these bicultural individuals resulting in differences in some social-emotional abilities, but not others. Another possibility is that there is a small, but real effect, and our results reflect a type II error due to the small size of our Western sample. The lack of difference between the East Asian and bicultural groups on both Empathic Concern and Personal Distress suggests that heritage plays a critical role in the development of empathic responding. Given the difference between the Western and bicultural groups on Personal Distress, it is quite possible that meaningful differences also exist on Empathic Concern, but are masked by a small sample size.

Our final goal pertained to the relationships between empathic behaviours and social-emotional health; particularly, do the significant relationships found in Western individuals also occur in those who are bicultural? Or do the empathic differences found in the bicultural group result in a different relationship with social-emotional health? The driving force behind this goal was to understand if East Asian individuals living in a Western culture share the same, or similar, empathic predictors for social-emotional health. This is critical as we found empathic differences between our bicultural and Western groups on elements of affective empathy and it was important to determine if these differences are implicated in the relationship with social-emotional well-being.

Consistent with research on Western individuals (e.g., Haughen et al., 2008), we found that affective empathy was strongly predictive of elements of social-emotional health in our bicultural sample. Specifically, we found that higher Empathic Concern predicted more Prosocial Behaviour, and greater Personal Distress predicted greater negative Emotional Symptoms while both lower Empathic Concern and higher Personal Distress predicted greater Peer Relationship Problems. This implies that the empathic differences found between bicultural and Western individuals may have widespread effects on social outcomes. This combination of findings: (1) that affective empathy predicts social-emotional health in a similar manner to Western groups (i.e., greater Personal Distress is associated with more Emotional Symptoms and Peer Relationships Problems) and (2) that there are differences in bicultural individuals' self-reported affective empathy (i.e., more Personal Distress than in the Western group), provides impetus for future research to further examine potential differences in the nature of social-emotional health outcomes across these cultural groups.

Implications, Limitations and Future Directions

The current study is one of the first of its kind to examine and establish cultural differences in affective empathy in a non-child sample, in addition to examining the effects of biculturalism on the components of affective empathy. Based on a plethora of findings that parents are a critical source of social and emotional learning at a young age and friends become increasingly vital to social learning as children age (for a review, see Harris, 2006), bicultural individuals are the ideal population for examining the relative influences of home versus community factors on empathy. Additionally, with many countries becoming more diverse there are many children born in one culture

from parents who belong to another. This can result in children trying to straddle two different cultural perspectives, behaviours, and norms in order to socialize both at home and outside the home, the effects of which are still largely unknown.

Our results imply that the bicultural individuals seem to adopt components of both groups' affective empathy, perhaps to facilitate socialization in both groups. The failure to find significant differences between the bicultural group and both Western and East Asian groups in their experiences of empathic concern is possibly because this factor is influenced equally by interactions within the family and interactions with peers. This could result from a change in relative importance of family versus peers across development. If young bicultural children are initially socialized at home, it is possible that they most resemble the parents' cultural group empathically; however, as these children enter schools in a Western culture and interact more with others in a Western culture, they may somewhat alter (or feel compelled to alter) what they learned at home to integrate and gain friends. The significant role peers have in social development for school-aged children supports such a change (e.g., Harris, 1995; Laursen et al., 1996; Tarrant, 2002; Chen et al., 2008).

The findings with respect to the experience of personal distress, however, were somewhat different. The bicultural group's lack of difference from the East Asian group and significant difference from the Western group suggests that the family (or perhaps heritage, in the case of individuals whose families have 'Westernized') primarily influences this component of empathy. If the family is the initial source of socialization for empathic behaviour, we would expect lower levels of empathic concern and higher levels of personal distress. Whereas empathic concern may become more influenced by peers with age, it is possible that personal distress is more resistant to change. One possible reason could be the early, and foundational, role of socialization by parents through their teaching of emotion regulation (Friedlmeier and Trommsdorff, 1999). Friedlmeier and Trommsdorff (1999) found that during a scenario where a play partner was in distress, East Asian (Japanese) mothers (of children aged two) did not expect her child to autonomously regulate her emotions and help the partner, but rather focused primarily on providing comfort for her own child. In contrast, Western (German) mothers did expect their children to regulate their own emotions and to provide help to a partner in distress. In turn, the Western mothers' behaviour emphasized their partner's emotional state and the need to help. Thus, individuals in an East Asian (i.e., 'collectivist') culture may inhibit empathic concern by increasing personal distress and affecting the way individuals are taught to regulate their own

emotions in distressing situations. Postulation aside, further research is needed to determine the precise causes of these cultural differences and the role each culture plays in the empathic responding of bicultural individuals.

Our findings also have crucial behavioural implications. According to our results, East Asian individuals are more likely to feel ‘self-orienting’ emotions in response to another’s distress, which in turn have been linked to lower levels of self-reported prosocial or helping behaviours (at least in Western cultures). This is seemingly in contrast to research suggesting higher levels of prosocial behaviour in East Asian cultures (Suzuki and Greenfield, 2002). This is not necessarily a logical impossibility, however. One possibility stems from work on emotion regulation that suggests feelings of personal distress can lead to prosocial behaviour when it is the quickest path to alleviate self-focused anxiety (Batson, 1998). Given that East Asian individuals also show higher levels of perspective-taking, which is related to higher levels of interdependence (Wu and Keysar, 2007), these individuals may be more attuned with others around them and their increased tendency to experience personal distress may induce helping as the easiest or most salient way to simultaneously reduce their own distress. Spun somewhat differently, it may be that the *nature* of the relationship between personal distress and prosocial behaviour is different in East Asian cultures (and those bridging East Asian and Western cultures), than it is in Western cultures. Thus, while the means of empathic socialization for East Asians could be different, the end result with regard to prosociality might remain the same.

Another possibility has to do with one’s sense of self. According to previous work exploring cultural differences in self-concepts and self-construals, North Americans hold a more consistent sense of self than East Asians, such that the core representations of their identity remains largely uninfluenced by others (Heine, 2001). Perhaps this quality of maintaining one’s psychological independence from others may decrease the likelihood that the self will ‘absorb’ the emotions of others. Rather than internalizing the distress of others, Westerners may empathize with those in distress by exhibiting concern rather than experiencing the corresponding negative emotions themselves. On the other hand, East Asians’ sense of self may be more dependent upon those around them, and in the context of empathic responding, adopting others’ emotions may be a key means by which East Asians better understand others and foster strong relationships (Morling et al., 2001). Again, this intertwining of emotions could lead to prosocial behaviour in order to alleviate the self-focused anxiety. It may be worth emphasizing that we are not suggesting that East Asians and this bicultural group are more ‘self-focused’ in an egocentric way; rather we surmise that this ‘self-focus’ is related to their

collectivist heritage which leads them to adopt the other person's distress 'as if it were their own'.

This latter possibility may also explain the current results with respect to empathy and social-emotional well-being. That is, if individuals are internalizing the experiences of others, these negative experiences can affect the observer's emotional response and in turn, social relationships. Unfortunately, to our knowledge, no previous work has examined the role of cultural differences in empathy and their relationship to social-emotional health. Thus, future work should further examine the relationships between empathic responding and social-emotional health in East Asian groups – both those living in Asia and those in Western settings where the higher rates of personal distress and lower rates of empathic concern have been associated with negative outcomes in Western groups.

There are, however, some limitations to the current study that must be taken into consideration. First, the measures included, for both empathy and social-emotional health, were self-report. There are known issues with respect to self-report questionnaires, namely the tendency to respond in a socially-appropriate or self-serving manner; furthermore, it is unclear how accurate individuals are at assessing their own cognitive and emotional states (for a review, see Eisenberg and Fabes, 1990). If possible, future research should focus on assessing the relationships between empathy and social-emotional health using behavioural measures of empathy. Second, the Asian group consisted only of individuals who were born in Asia but who have spent at least some time living in Canada. Although they did not self identify with their new Western culture, it is possible that this time spent in Canada, however limited it may have been, could have influenced them enough to make them meaningfully different from Asian individuals who were born and raised in an Asian country and continue to reside there. Thus, our Asian sample may also be seen as being somewhat 'bicultural'. Comparisons with a 'pure' Asian sample are necessary before making firm conclusions involving this group.

In sum, the current results suggest that there are cultural and bicultural differences with respect to affective empathy. Specifically, East Asian adolescents and young adults reported less empathic concern and greater personal distress than their Western counterparts. The scores of those who self-identified as bicultural fell in between the East Asian and Western groups, but revealed significant differences from their 'uni-cultural' peers, demonstrating shared influences of family and community. The mechanism behind these differences warrants further investigation, but these data provide a vital first step in a better understanding of the role of culture in empathy. The current results also demonstrated that the relationship between empathy and levels of

social-emotional health in a bicultural sample is similar to that for Western individuals. That is, affective empathy was strongly predictive of elements of social-emotional health. Specifically, we found that higher empathic concern predicted more prosocial behaviour, and greater personal distress predicted greater negative emotional symptoms, while both lower empathic concern and higher personal distress predicted greater peer relationship problems. This ‘bicultural’ group, which as of yet has been understudied, clearly merits further research – both as a means to better understand the effects on those who bridge two cultures (something that has become increasingly common in recent years) and as a means to advance understanding of the differing roles family factors and broader community factors play in empathic development.

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