

# Chapter 2

## Globalization: Psychological Problems and Social Needs

Richard H. Dana and James Allen

### Introduction

Globalization fosters a re-examination of multiculturalism in the United States. Existing historical multicultural populations comprise assimilated or bicultural affluent and professional class resident ethnic minorities as well as a resident ethnic minority underclass. In addition, rapidly expanding new multicultural populations include migrant laborers, refugees, and transnational elite students and sojourners. These new populations maintain their occupations and activities by necessary, regular, and continuing social contacts across national boundaries and work settings in diverse cultures. Transnationalism in these new multicultural populations produces a sense of common history with shared affective bonds of culture, language, and religion in the absence of continuing affiliation with either their original or host societies. These individuals have reconstituted identities that include awareness of deterritorialization, a loss of traditional and dedicated living space as a result of exclusion, discrimination, and distinctive human problems.

The unprecedented mobility of these new, diverse multicultural populations in order to remain alive or pursue improved living conditions has resulted in counter pressures by host countries to maintain the status quo. These counter pressures stimulate ethnic unrest and contribute to the development of psychopathologies and problems in living that remain largely unrecognized, unaddressed, and unresolved. Pre-existing psychological injury, histories of trauma, culture shock, and negative and/or incomplete acculturation experiences arising from culture-specific expectations, beliefs, and worldviews, with cultural identification issues contribute to these sources of distress.

The magnitude, prevalence, and universality of human problems associated with transnational identities transcend nationality, ethnicity, and race. A unified behavioral health psychology in concert with interactive social science disciplines is needed to understand and alleviate these problems. Part of this new understanding entails reframing the science-practice relationship in order to provide services recognizing the dimensions of human distress in these new populations. A

re-examination of the nature and conduct of psychological science is necessary as a precursor to changes in social policy that can alleviate existing and emergent social problems affecting these increasingly large population segments. In this endeavor, globalization impacts psychology as a catalyst for developing international knowledge.

To date, however, there has been only a limited recognition of the magnitude and prevalence of psychological distress in these multicultural populations. All life domains are permeated by the contemporary struggles of these populations to ensure survival and to validate their humanity. Contemporary efforts describing these new populations permit an examination of the kinds, range, and prevalence of population-specific sources of distress and social needs.

These sources and manifestations of distress transcend existing medical model illness formulations and necessitate equivalent conceptualization and research to identify and address sources of nonpathological distress as well as social disorder. An understanding of physiological concomitants of distress, negative emotions, and unhealthy workplace behaviors preceded the development of a Holistic Stress Model. This model introduces *eustress* as a context for developing and applying workplace opportunities for performance and achievement that contribute directly to health and well-being in daily life.

## **Globalization**

Globalization has altered concepts of space and time, increased cultural interactions, provided common problems, and fostered new problem solving by comprehensive networks of transnational actors and organizations. This is all orchestrated within the context of globalization by interconnections, interdependencies, and synchronization of economic, technological, political, social, and cultural dimensions (R. Cohen, 2006). Globalization also provides an interface of potential economic advantages and emergent human issues. New economic opportunities are dependent upon unprecedented mobility within a context of infrastructures encouraging access to education and facilitating assertion of human rights. Economic globalization, however, differentially includes and excludes nations and social groups in world capitalism. As a result human insecurity and inequality increase simultaneously in a context of new economic opportunities (Castles, 2007).

In order to conceptualize the human responsiveness to globalization, Olzak (2006) developed a heuristic model of world-level processes and country-level factors impinging on these groups to create counter pressures that discourage and retard the efforts of minority populations to surmount historic inadequacies in living conditions. World-level dependency is associated with diffusion of human rights ideology and social movements. Country-level factors include poverty, inequality, exclusionary policies, and state restrictions. At the group level, cultural differences, competition for land, internal resettlement, and discrimination result in ethnic-political mobilization. As a consequence of ethnic political mobilization, ethnic tension

and violence can occur. International nongovernmental organizations, policies for ethnic groups, and formal civil rights provide incentives for ethnic nonviolent protest.

Globalization has also increased awareness, communication, learning and sharing of knowledge among professional, scientific, and business organizations employing English as the *lingua franca*. Globalization encourages the development of shared interdisciplinary knowledge essential for informed awareness of common problems and constructive services for individuals from the behavioral health and social care systems that serve them. Globalization impacts psychology at the macro- and microlevels. At the macrolevel, globalization leads to re-examination of the nature and conduct of science and the formulation of social policy for the alleviation of social problems. The Internet provides new opportunities for informed consensus on the nature of legitimate scientific activities affecting the science-practice relationship. At the microlevel, globalization is potentially capable of driving services that address individual human problems within their cultural contexts.

English, a first language for over 400 million and a second language for over 1 billion, has become an international language on the Internet for a plurality of users (The Economist, 20 December 2001). Internationally English is the language of science, communications, business, aviation, entertainment, and diplomacy. English is now compulsory not only in educational systems in Europe, Canada, Australia, New Zealand but also in locations as diverse as China, Hong Kong, Japan, India, Kenya, Kosovo, Liberia, Mongolia, Mexico, Pakistan, the Philippines, Singapore, South Africa, and Zimbabwe. Despite the predominance of English in the economic and political aspects of globalization, a resurgence, continuation, and perseverance of many original languages has occurred as facilitated, for example, by information available in Google in 116 languages. Friedman (2006) describes this phenomenon as *globalization of the local*.

Major social changes accompany global Westernization. These include rapid, massive population growth, unprecedented displacement and migration/immigration, widespread human rights violations, increasing crime, violence, and substance abuse, clashes between cultural groups, and destruction of indigenous cultures (Marsella, 1998). These events and forces are of special relevance for mental health and psychological well-being. To understand and prepare for simultaneous societal change and complementary individual coping reactions, Marsella advocated a new international global-community psychology predicated on multidisciplinary, multicultural, and multinational interests facilitated by mutually respectful affiliations and interconnections.

Globalization has facilitated the development of this metadiscipline incorporating clinical, counseling, and community psychology as well as cross-cultural psychology and cultural psychology at macrosocietal and microindividual levels. Hitherto isolated psychology research specialties across international settings can increasingly interface, interact, and debate scientific issues of mutual interest. As a consequence, an enhanced potential exists for the nature and conduct of psychological science to be more readily understood, and consensual applications of this science can develop, serving to blur the discrepancy between science and practice.

A global-community psychology recognizes that these events and forces associated with globalization are primary socialization influences affecting human well-being in contemporary societies. Monocultural mental health systems and their inherent cultural biases are now obsolete in terms of their abilities to address these issues, and must be replaced by culturally responsive systems of mental health and social care. To prepare for these systems of care, Marsella (1998) suggested a broad spectrum of global psychology undergraduate preparation as part of the preprofessional training for all behavioral health disciplines.

At a micro- or individual psychological level, globalization has been responsible for developing an emergent bicultural-bilingual identity that constitutes an international culture composed of two socioeconomic classes, determined by educational status and the information technology skills critical in contemporary societies for learning, analysis, communication, and the development of human relationships (Arnett, 2002). Among this new international culture population, the underclass poor, composed primarily of migrant service workers, along with refugees and asylum seekers, are the human byproducts of globalization. The acculturation process for individuals who successfully navigate international or resident ethnic minority status occurs at the group and psychological levels and proceeds according to integration, assimilation, separation, and marginalization strategies (Berry, 2006). Individuals who pursue integration strategies find acculturation is less stressful and experience better adaptations than those employing marginalization.

## **Psychological Science Re-Examined in Global Context**

Contemporary psychological science is not a coherent body of universal assumptions, methods, and findings. Instead, it is characterized by a set of diverse products from belief and value systems developed within particular societies. The current status of this science reflects a history of interrelationships between religious, political, and social organizations combined with a skeptical attitude toward the relevance of conceptualizations originating from other national and cultural entities.

Psychological science is culturally conditioned, although consensus is emerging within this science consistent with recent globalization ideals expressed by international psychological organizations. For example, *The Counseling Psychologist* now has an International Forum that permits our local, national understanding of cultural diversity to be cognizant of and responsive to international global perspectives (Leong & Blustein, 2000). A global psychology can affect humanity by clarifying local cultural origins of contemporary scientific thought (Pedersen, 2003; Pedersen & Leong, 1997). Consensual international standards can advance a more inclusive practice of psychological science (Leong & Ponterotto, 2003). Psychology has an important role in understanding the historical, cultural, and intergroup dynamics of the immigration process by contributing to outcomes that benefit host countries and contribute to the well-being and achievement of immigrants (Dovidio & Esses, 2001).

Common global problems now necessitate reconsideration of how psychological science is classified among scientific disciplines. Psychological science faces new demands for accountability, increasing cultural knowledge in a knowledge/information framework, and applications to resolve ethnic conflicts (Rosenzweig, 1999). As a critical component of this endeavor, Rosenzweig emphasized the role of the International Union of Psychological Science (IUPsyS) in relationship with the UN, UNESCO, and WHO, as well as other international science organizations (e.g., International Social Science Council, International Council for Science), and their affiliated psychological organizations.

As a result of globalization, national and international psychological research enclaves have increased their mutual awareness and intercommunication and now inform each other. These component disciplines of Cross-cultural Psychology, Cultural Psychology, and Indigenous Psychology are all concerned with psychological research on culture-behavior relationships, although each discipline emphasizes different conceptual and methodological approaches (Costantino, Dana, & Malgady, 2007, Chap. 2; Greenfield, 2003). Nonetheless, these disparate approaches are complementary because they all transport empirically derived information across cultural contexts. In addition, they advance understanding by examining the validity and cultural equivalence of current psychological knowledge (Berry, 2000) that guides the behavioral health professions.

## **Psychopathology and Problems in Living in Multicultural Populations**

All populations in the United States, including mainstream and multicultural groups, now share a similar dilemma. Both face untreated psychological problems and social needs because of limitations in the existing systems of care (Kessler et al., 2001). Approximately 23% of the entire U.S. population will experience a diagnosable disorder during a 12-month period, for which only a small proportion will actually receive services. Worldwide, over 450 million will experience a behavioral health disorder, accounting for 25% of all disability in major industrialized societies (World Health Organization, 2001). However, significant disparities continue to exist in the numbers of untreated individuals and the accessibility of services for members of ethnic minority groups.

These sources of distress are more chronic and more severe, and their consequences more neglected among multicultural racial/ethnic minorities in the U.S., in contrast to the ethnically homogeneous, mainstream populations (Kataoka, Zhang, & Wells, 2002; Snowden, 2003). While representative population prevalence estimates of child/adolescent psychiatric disorders in the United States are incomplete, data for these disorders in Great Britain and Australia are available (Costello, Mustillo, Keeler, & Angold, 2004). The resulting international prevalence estimate of rates for children and adolescent psychiatric disorder is approximately 25% and includes the United States.

Psychosocial disorders, particularly antisocial behavior, have increased markedly (Smith & Rutter, 1995); cross-cultural research comparisons are needed to examine shifts in moral concepts exposing conflict between individualistic values and rising expectations. Systems of care generally provide a medical/psychiatric perspective and thus fail to recognize nondiagnosed problems in living or social needs due to cultural/racial identity and acculturation status as well as poverty, social class, oppression-induced conditions, disability, or advanced age.

## **Population-Specific Sources of Distress**

Chapter 1 described the human faces of globalization in five major at-risk populations. This global culture now constitutes a social system that includes historically underserved resident multicultural populations and a new multicultural resident middle class, along with burgeoning new international groups of affluent, educated bicultural-bilingual elite sojourners and less advantaged migrant laborers and refugees.

These new populations contain immigrants motivated by hope for economic betterment as well as displaced persons searching for personal safety and survival. Displaced persons, victimized by trauma, torture, imprisonment, and human rights violations during the last 20 years, have resettled in the Americas, Europe, and Asia (United Nations High Commissioner for Refugees, 2006). These unwilling immigrants have experienced multiple sources of distress, incursions on core human adaptations in security/safety, attachment, justice, role/identity and existential meaning systems as well as acculturation and psychopathology dilemmas. They also bring with them their original cultural identities, world views, and constructions of reality as well as traditional forms of psychopathology, problems in living, group-specific and culture-specific sources of distress and acculturation issues.

For example, in Lisbon, there are affluent Asian Indian merchants and immigrants, along with refugees from former Portuguese colonies in Africa living in segregated enclaves and favelas. Filipinos migrant laborers are in Arab countries, North Koreans work in Japan, and Mexicans labor in the United States. While the Asian Indian merchants are self-sustaining and assimilated, the underclass migrants in all these host countries are second-class residents, typically exposed to oppression and exploitation. All these groups are dependent primarily on behavioral health services designed for psychopathologies recognized by their host societies, and there are very limited culturally competent services responsive to their culture-specific expectations and health/illness beliefs. There is also infrequent recognition that social care is required for acculturation dilemmas and other problems in living. Typically, migrant and refugee populations also bring with them their own healers for culture-specific services. These indigenous healers have histories of coping with traditional problems and culture-bound psychopathologies rather than the novel sources of distress resulting from immigration, and they are generally not affiliated with host society behavioral health personnel and facilities.

In the elite sojourner group, a relatively small number of individuals, in contrast to the larger number of migrant service workers, have unprecedented new opportunities for freedom, prosperity, and influence beyond the confines of their national borders. The talents and potential power for productivity and positive social impact by these individuals should be reciprocated by a special responsibility by host nations and their employers to maintain their health and well-being. As is the case for their historic and resident multicultural populations, the available behavioral health services are designed for psychopathologies recognized by the mainstream group in host societies, and limited national resources are generally allocated for culturally competent services. As a result of these deficits in behavioral health care systems, international employers are called upon to provide a range of services for all forms of human distress in order to ensure a well-functioning workforce.

Immigrant and migrant populations are increasingly distanced and differentiated from one another in the U.S. and Europe, and compartmentalized in their daily activities and association. Furthermore, multicultural resident elites are alienated from the poverty-ridden underclass populations including migrant labor enclaves in both their countries of origin and in the United States or other host countries. This is despite the fact that both these populations are exposed to prejudice, discrimination, and racism to at least some degree, dependent on skin color, country of origin, religion, affluence, English language fluency, education, and social skills.

In the United States, some states have reached critical ratios of multicultural populations. In these locales, services have been mandated, and population-specific attention to some of their concerns has occurred. Nonetheless, behavioral health, profession-specific attention to these diverse populations and their manifold sources of distress remains limited. As the United States as a whole reaches critical mass and becomes a truly multicultural society, the objectives of concerned behavioral health professions are gradually becoming more inclusive of minority populations, particularly in the states where these populations exceed critical ratios, such as California. There are also beginnings of more unified interdisciplinary professional alliances along with international attempts to recognize and relieve these new and continuing human problems within these emergent populations.

## **Resident Minorities**

Resident minority acculturated middle-class and upper-class racial/ethnic populations in the United States are sufficiently assimilated or bicultural to recognize that they are obligated to share existing mental health services designed for a relatively homogeneous White population in both the public and private sectors. This sharing occurs as a combined function of income, health insurance, acculturation status, and health-illness beliefs. However, they recognize continuing problems of access to public sector services and disparities in available services (Snowden & Yamada, 2005) that may not be appropriate or necessarily beneficial for their presenting problems. For example, service providers often lack the cultural knowledge to provide

cultural formulations to minimize misdiagnosis or recognize culture-bound syndromes.

As subsequent chapters will examine, services for problems arising from discrimination and oppression may be unavailable, especially from experienced White service providers. Moreover, many service providers have generally not been trained to provide culture-specific services, particularly for Bicultural and Marginal acculturation orientation clients who retain elements of their original languages and cultures, and experience high frequencies of culture-bound syndromes and culture-specific symptom expression. This dilemma is shared by the multicultural underclass and its elite.

## **New Impoverished Multicultural Underclass**

In the United States, poor persons in general along with multicultural populations continue to anticipate and experience lower life expectancies, higher rates of injury, and exacerbated health and mental health problems. They are more likely to not have insurance of any kind, and are more vulnerable to health emergencies, homelessness, violence, daily hassles in living, and local catastrophes (e.g., the aftermath of hurricane Katrina in New Orleans). These residents are in dire need of societal alterations that address social inequality rather than conventional psychological interventions per se. However, outreach, consultation, self-help/social support, prevention, and expanded community services consistent with social justice objectives are essential (Atkinson, Thompson, & Grant, 1993). In addition to historically disadvantaged resident ethnic minorities, new multicultural groups comprising an impoverished underclass in the United States include migrant laborers, refugees, and asylum seekers.

### ***Migrant Labor***

Migrant workers in the United States are part of a worldwide service industry that once included a large percentage of documented visiting workers. Due to shifts in immigration policy a majority of these workers, particularly in agriculture, are now included with undocumented and illegal aliens. These migrant workers and their families must learn a new language and culture, move frequently, experience economic poverty, discrimination, and workplace exploitation. Adults and often their children all work under potentially aversive and toxic conditions, child care and health care are generally not available, and living conditions are overcrowded and unsafe. In addition, they often face discriminatory immigration and educational policies undermine well-being.

In United Kingdom, a case study of Brazilian, Polish, Turkish, and Kurdish migrant workers (Jordan & Duvell, 2002) provides description of a different process. These groups share a primarily legal entry experience and work without proper

work status. However, individuals used differing entry strategies, and their stay could be with or without challenge to immigration rules. These authors describe a less regulated, more flexible, low-pain shadow economy in the UK distinct from the European Community. Resident communities, informal local and transnational networks, grassroots and self-help organizations, governmental agencies, and NGOs provide aid and support for continued residence of immigrants. Yet both the Brazilians and Polish irregular immigrants did substantially better than Turkish migrants on a number of quality-of-life indicators. These Turkish migrants were forced by the government to choose between asylum seeking with restricted rights or illegality without proper legal or work status, which thereby “*both* pushed them into a cycle of immiseration and perpetual legal struggle, *and* drove them toward activities which were outside the law” (p. 167). Societal “welcome,” in this national instance, illustrates the necessity for new social justice institutions, in the words of these authors, “consistent with the world of sovereign political communities, but enable justice within and between them. The present combination of trade and aid has failed, both because it consolidates and reinforces inequalities, and because it destabilizes redistributive regimes” (p. 244).

Clare and Garcia (2007) have examined the hitherto silent educational area of immigrant children from poor migrant families in the United States who suffer from pervasive and continuing attempts to limit access to education. These authors report that the federal demographic designation Hispanic now contains a majority of school-age children. Access has been thwarted through the systematic elimination of bilingual education and one-year English immersion classes for Hispanic youth. Bilingual instruction requires 4–7 years and English immersion requires 7–10 years to support adequate academic functioning. Mandated grade-level achievement tests often require retention in grade for inadequate performance and thus retards academic progress and creates an artificial educational ceiling for many children.

Access in a democratic society should include “every opportunity a mainstream student has relative to relevant and effective curriculum, quality instruction, support services, and educational and extracurricular activities” (Clare & Garcia, 2007, p. 552). Denying these children educational opportunity is not only discriminatory but also has lifelong effects on problems in living, well-being, and quality of life as well as on the societal health and prosperity of the nation.

Migrant children require culturally consonant school settings that instill a sense of belonging, stimulate expectations, facilitate parental involvement, and respond to their daily realities through, for example, breakfast and lunch programs. Schools require personnel who are knowledgeable concerning the social context of these children as a result of training and/or shared ethnicity and cultural experience. At present, most school staff are White women, and multicultural training for teachers and school psychologists is still limited (Reschly, 2000). This social context of migrant children, described by Clare and Garcia (2007), includes several inherent strengths schools can access, including strong family values, work ethic, importance and valuing education, and spirituality. Cross-cultural school psychology competencies in 14 domains have been proposed, and these domains can provide the multicultural training needed by school personnel (Lopez and Rogers, 2007).

## ***Refugees***

Refugee characteristics may overlap with other emergent populations, although refugees and asylum seekers typically differ in their heterogeneity across social classes, occupations, and language skills, as well as in their histories of trauma and forced migration for continued survival. Host countries have pathologized a broad spectrum of refugee behaviors under the diagnosis of PTSD. Following resettlement, host societies have often disregarded the incursions refugees have experienced on their humanity resulting from traumatic human rights violations, as well as their more everyday immediate need for social support and facilitation during the acculturation process. Host countries have differential “welcome” and vary in the resources they make available for refugee assistance with acculturation. However, the restoration of psychosocial meaning systems by informed and sensitive interventions has not generally been assumed as a public sector responsibility in host societies.

In the United States, for example, a human science approach to refugee mental health concerns with a central focus on personal and cultural differences was largely repudiated by a cognitive-behavioral, manualized approach to professional practice. As a consequence, there are few centers for refugee problems to provide specialty services for the 500,000 refugees currently residing in the U.S. The healing of refugees perforce requires multidisciplinary inputs to encompass their diverse needs. This requires a holistic health perspective emphasizing individual and culture-specific sources of strength and resilience, discussed later in this chapter (Dana, 2007a).

Although the nurture of individual humanity is a minor pursuit among professional caregivers in the United States, in Latin America and Europe, however, basic psychology training leads directly to professional practice with advanced training in psychological specialties as preparation for academia. As a result, an enlarged conception of psychological science has permitted the development of special resources in research settings for refugee populations, although these resources are not generally applied in public sector professional practice settings. Next, we will explore how within the context of globalization, many similar needs are often present even among more advantaged and privileged new multicultural populations that comprise a new transnational elite.

## **Transnational Elite**

### ***Students***

In host countries, international student sojourners experience distress due to culture shock, as learners in transition, and prior to re-entry into their home cultures. These problems are amenable to interventions by culturally competent personnel in many university counseling centers (Arthur, 2004). Culture shock, as a syndrome of stress,

includes common psychological and physiological symptoms (see Arthur, p. 28) and also can have positive effects leading to normalization by interventions providing symptom reduction and increasing coping skills (Chen, 1999; Merta, Strongham, & Ponterotto, 1988). These therapeutic experiences can have positive effects leading to greater long-term adaptation skills.

### ***Professional-Managerial***

Professional-managerial employees in organizational climates historically have experienced situations where erosion of morale has occurred due to work-related stress, distress, and conflict. Globalization, dislocation, and an increasingly diverse workforce provide increased sources of emotional turmoil that impact motivation, interpersonal interactions, job performance, and workplace satisfaction. Ultimately, these conditions result in physical and/or psychological symptoms among employees that may be addressed by workplace health promotion informed by a public health model. Organizations now employ more complex, nonbureaucratic models with frequent restructuring to accommodate multiple, disparate goals (Bennett, Cook, & Pelletier, 2003). This model contains primary, secondary, and tertiary levels for individuals not at risk, at risk, or with health concerns. Thus, a continuum of interventions encompasses preventive regimens with joint individual-organizational responsibility, psychological interventions, and medical-psychiatric treatment. We conclude this chapter by arguing that this model, and its application in multicultural organizational settings, has important implications for culturally competent services in behavioral health systems of care.

## **Holistic Models of Stress and Well-Being**

Occupational stress, however, has long been recognized and examined in a context of employee health and well-being. As economic globalization is accompanied by greater numbers of multinational corporations, these sources of stress and erosion of well-being occur in an increasingly multicultural workforce. A recent series of five volumes, *Research in Occupational Stress and Well-Being*, edited by Perrewe and Ganster (2006), addresses this history, reports research, and describes primary and secondary intervention strategies. A panorama of research is presented to document the physiological impact of stress, the effects of stress on the individual and family and the impact of negative emotions, and the impact of unhealthy behaviors leading to formulation and examination of a Holistic Stress Model.

### ***Physiological Concomitants of Distress***

Sonnentag and Fritz (2005) describe how acute and chronic psychological distress increases neuroendocrinological reactions that increase the levels of

catecholamines (i.e., adrenaline and noradrenaline) and cortisol. These authors reported a meta-analysis of 208 laboratory plasma studies of cortisol response. In these studies, control response was markedly affected by interactions involving public speaking and cognitive tasks. These tasks were characterized by threat of negative social evaluation through video recording, the presence of evaluators, or negative social comparison. In addition, outcomes included an element of uncontrollability in situations that precluded certainty regarding desirable outcomes or inevitable negative consequences. Serum cortisol levels have sufficient sensitivity for use in employee examinations before and after expatriate assignments, altered job demands, decreased feedback from superiors, changed health status, or pressure due to relocation effects on families. Recovery of adrenaline baselines from occupational stress may be prolonged and have long-term effects on health, or may occur with relative immediacy as a function of individual differences psychological stability. Supplemented by psychological measures, physiological measures provide important measures of employee well-being.

### ***Negative Emotions***

A health consequences model charted the progression of conflicting family and work demands, personal and social resources, and the arousal of negative emotions by interference in either the family or work domain (Greenhaus, Allen, & Spector, 2006). Negative emotions disrupt activities in both work and family domains, and lead to life dissatisfaction, poor physical health, and unhealthy behavioral outcomes. These emotions are inconsistent with dominant social-organization norms and values, and as a result have been underreported until recently (Meyerson, 1990).

### ***Unhealthy Behaviors***

Unhealthy interpersonal behaviors aversive to employers, including aggression/violence, alcohol/drug abuse, and depressed mood, occur frequently among employees (Perrewe & Ganster, 2006). For example, behavioral cynicism-cynical humor and cynical criticism are externalizations of work-induced stress that affect not only job performance but also the lives of employees outside of work (Brandes & Das, 2006). Ultimately, these behaviors can be socially isolating or self-defeating, and induce feelings in the employee of a lack of effectiveness and accomplishment, or burnout. As a moderator variable between stress and performance, cynical criticism can also result in performance decrements under conditions of high stress.

As difficult colleagues, these employees may be encouraged to learn self-talk (see Quick, Mack, Gavin, Cooper, & Quick, 2004, Table 2 for examples). Self-talk may originally be suggested by others and, if accepted, can provide a constructive,

positive interpretive style of thought, described by Seligman (1990) as learned optimism. These employees may also benefit from temporary distancing from workplace ambiguities and frustrations through catharsis, shared insight, more healthful self-perspective, and social support to avoid depression.

### ***Holistic Stress Model***

Nelson and Simmons (2003, 2004, 2006) define work stress through job conditions, workplace policies, interpersonal, physical, and role demands. In the Holistic Stress Model (HSM), individual differences in Hardiness, Locus of Control, Optimism, Self-reliance, and Sense of Coherence influence the perception and appraisal of stressors and mediate positive – eustress – and negative – distress – psychological state effects. These psychological state effects are measurable by variables each possessing independent histories of psychological research. Distress signals are measured by state negative affect, job alienation, anger/hostility, anxiety, and burnout. The positive stress effects, or eustress, channel the stress response into constructive and measurable outcomes, including state positive affect (Watson, Clark, & Tellegen, 1985), meaningfulness and manageability (Antonovsky, 1987; Artinian, 1997), and hope (Snyder, 2002; Snyder et al., 1996). Thus, these eustress components provide major avenues for understanding the dynamics of resistance to stress, and more broadly, adaptive capacities that lead to the development of individual, group, and societal resources for health and well-being. The HSM outcomes associated with well-being in health and work performance are supported by studies of hospital and home health care nurses, professors, and pastors. In these studies, hope enables individuals to cope responsibly with change and fulfill workplace goals by managing eustress (Nelson & Simmons, 2006).

The HSM employs *interpersonal trust* in leadership, defined as willingness to be vulnerable to a supervisor (Mayer, Davis, & Schoorman, 1995). Trust in leadership by a direct leader or organization has a 50-year history across multiple disciplines. During the last 30 years it has become a major research theme. Dirks and Ferrin (2002) provided a framework to align leader actions/practices, follower attributes, and relationships with affective-cognitive definitional components and with outcome behavioral/performance dimensions, job attitudes/intentions, and correlates. The dimension of interpersonal trust is an important determinant of whether a work stressor generates distress or eustress.

Eustress focuses on the role of positive relationships in determining employee perceptions of health/well-being. Employee perceptions of *health and well-being* are measurable outcomes in successful adaptation from the stress response (Ware, Davies-Avery, & Donald, 1978). Health and well-being are long-term, established outcomes of successful coping with stress, while eustress effects are beginning to receive comparable research attention (Edwards & Cooper, 1988; Nelson & Simmons, 2004; Quick, Mack, Gavin, Cooper, & Quick, 2004). HSM health/well-being outcomes potentially include physical health, mental health, work performance,

spouse's health, marital quality, quality of care for children, quality of friendships, and community involvements (Nelson & Simmons, 2003). These potential eustress outcomes are in marked contrast with historical research on work stress outcomes such as absenteeism, worker conflict and turnover, as well as health care costs and workers' compensation claims estimated by these authors to aggregate at over \$200 billion annually.

Quick and colleagues (2004, 2006) provide a rationale of assertions/caveats for executive-driven stress, an intermediate level of distress distinct from abuse that depends upon employee-organization alignment and open communication. Nine principle-based dimensions designed to develop positive, eustress work environments complement their rationale. These principles describe actions to craft challenging goals, create trusting relationships, and encourage a learning culture. This work environment includes open communication, encourages exploratory behavior, celebrates small successes, capitalizes on workforce diversity with constituencies and individuals who accept constructive conflict and were selected for personality-based goodness of fit. Each principle is discussed as an outcome of research.

### ***Workforce Globalization***

Globalization has increased the numbers, power, and recognized skills of employees who are women, resident ethnic minorities, and international migrants. At the same time, opportunities for stress increase as the workforce becomes multicultural in composition (Jackson & Saunders, 2006). Elite employees who differ from their White European or American managers in racial/cultural/national origins may also experience cultural confusion and acculturation process difficulties, while gender difference interactions with cultural background may contribute to emotional turmoil and restrict work efforts affecting extrawork activities as well as family interactions (Maume, 2006).

A new multicultural, multinational workforce has resulted in managerial attention to cultural diversity as an impetus for organizational effectiveness. These new human resources provide a competitive advantage due to increasing creativity and innovation, problem-solving quality, and organizational flexibility as dimensions of business performance (Cox & Blake, 1991). More recently, specific culturally relevant workforce problems are increasingly addressed in informational research briefs describing employee selection (Kravitz, 2007), receptivity to leadership styles (Zhu, 2007a), knowledge sharing (Voelpel, Dous, & Davenport, 2005), reward allocations (Zhu, 2007b), and well-being (Wright, 2006).

These specific problems and examples provide evidence for a shift from a multicultural perspective to a cultural hybridization approach. A multicultural perspective recognizes cultural differences, yet relies upon indoctrinating local managers from a variety of cultures to standard Western ideas and practices per se. Instead, by merging local and Western management policies a new hybrid corporate management emerges in which "flexible practices are based on participative systems and they

express themselves in values such as equity, participation, openness, innovativeness and creativity” (Shimoni & Bergmann, 2006, p. 76). These authors provided Israeli, Thai, and Mexican managerial examples from global corporations headquartered in the United States and Sweden.

In a similar vein, there has been global movement from general cultural advice/admonition and specific cultural information toward a research-derived basis for conceptualizing leadership differences for American executives in diverse countries. This sophisticated, successful, multilevel, multimethod global enterprise emanates from a cross-cultural perspective incorporating, balancing, and synergizing etic, pancultural or culture-general conceptualization, with emic, or culture-specific local concepts described eloquently in the Forward of the most recent volume by Leung (2007).

The Global Leadership and Organizational Effectiveness (GLOBE) project was a 10-year research program investigating the impact of specific cultural variables on leadership effectiveness and organizational cultures in a broad sample of international societies (Chhokar, Brodbeck, & House, 2007; House, Hanges, Javidan, Dorfman, & Gupta, 2004; Javidan, Stahl, Brodbeck, & Wilderom, 2005; Javidan, Dorfman, Sully de Luque, & House, 2006).

GLOBE employed 175 crosscountry investigators from 61 societies with three representing each geographic region. A total of 951 participant organizations represented food-processing, financial services, and telecommunication industries, and over 17,300 middle managers. These managers completed culturally sensitive questionnaires providing data on leadership and organizational culture. The researchers conducted in-depth ethnographic interviews, focus groups, participant observation, unobtrusive or nonreactive measurements, and media analysis. Nine global dimensions were measured using Hofstede (1980, 2001) antecedents (i.e., Gender Egalitarianism, Assertiveness, In-Group Collectivism, Institutional Collectivism, Power Concentration vs. Decentralization, Uncertainty Avoidance) and other origins (i.e., Future Orientation, Performance Orientation, Human Orientation). Managers described leadership by critiquing their resident society practices “*as is*” and “*should be*” values in terms of global styles/dimensions (i.e., Charismatic/Value-Based, Team Oriented, Participative, Humane Orientation, Self-Protective) and specific attributes/behaviors.

However, to date this organizational psychology literature has not received widespread consideration by national and international employers, perhaps out of mutual distrust between research academicians and executive practitioners. There have been notable research studies and conceptualizations to date (e.g., GLOBE and Cultural Hybridization). However, these exemplars have apparently not persuaded executive practitioners in multinational organizations with multicultural workplace populations to extend research recommendations to managing their multicultural employee populations. This is particularly true with regard to systematic, differential, and culture-specific interventions for distress as a function of cultural identity. Careful mapping of cultural influences on occupational stressors within multinational employers has not occurred. This is despite the clear research documentation of the physiological and psychological concomitants of distress, and evidence for

the effectiveness of culture-general and culture-specific preventive, supportive, and interventional remedies for occupational stress.

## **Health/Well-Being Resources in Nations and Organizations**

This chapter's relevance to the theme of this book is apparent in what we know about human problems historically and as a byproduct of globalization, and how nations and organizations differentially understand and attempt to alleviate the resulting distress. Several sets of contrasting perspectives illustrate the contemporary dilemmas accompanying globalization. First, nations and organizations invest their human-problem solving energy and resources very differently. Many Western nations remain persuaded that monocultural tertiary interventions for psychopathology within medical model systems of care are sufficiently inclusive for all their populations. In these local endeavors, particularly in the United States and the European Community, multicultural populations are coerced, using legal restraints and available interventions, to acculturate and assimilate in order to benefit from societal care facilities. Resident populations that are culturally different from the relatively homogeneous mainstream and who choose to retain these differences over time are generally ignored and their differences minimized, even within the research models that guide practice.

Although organizations in the United States have conformed to the research model that minimizes cultural differences, their efforts have been directed toward primary- and secondary-level preventive interventions, and in particular a workplace health promotion model. These organizations provide an alternative, distinct from the contemporary managed-care emphases on psychopathology within a medical model aegis that characterizes much of the private and public behavioral health system of care in the United States. These two systems of organizational and behavioral health function dichotomously because of dissimilar societal purposes and objectives, with the exception of a shared science-practice orientation that is disinclined to fully explore individual and culturally based human differences.

In the United States, organizational health psychology has generated research and practice approaches toward comprehensive organizational wellness epitomized by workplace health promotion (Bennett et al., 2003). These authors describe healthy workplace characteristics including multidimensional assessment of well-being instruments, multilevel descriptions of organizational health, and self-assessment monitoring. These practices provide congruence between the organization and the market, economy, and social community by addressing core organizational tensions within cycles of growth, regression, and deterioration. Stress-related disorders in the 1980s were responsible for pervasive absenteeism and a majority of healthcare provider visits (Quillian-Wolever & Wolever, 2003). These authors present an informed and comprehensive lexicon of primary and secondary prevention techniques for managing work stress. However, neither of these two previous reviews mention cultural issues, an omission mirroring a broader trend within psychological science

to maximize human similarities, and to disregard or minimize individual differences. This supports the myth of a monocultural society.

In contrast, cross-cultural psychology offers a more inclusive model of psychological science in the emerging new context of globalization. It relates both emic and etic considerations, combines quantitative and qualitative methodologies, and seeks to incorporate research participants and their communities into the design and practice of research. This broader perspective is exemplified by the GLOBE project. However, while the GLOBE project resolves some parochial psychological science issues, it also illustrates the continuation of a science-practice dichotomy. Psychological science antedates practice in the modern world, but more effective and convincing translational efforts in the application of this knowledge must occur to make a difference in the welfare of human populations.

In unfamiliar host cultures, all migrating multicultural populations require local services not only for psychopathologies. Local assistance with employment, housing, language and coping skills during the acculturation process is important for successful adaptation, as is human healing from earlier trauma. Host countries have been slow to address the problems of these new populations. These host country political systems generally fail to recognize the nature and expression of cultural realities that generate culture-general and culture-specific psychopathology and symptom expression. These systems also exert profound effects on the acculturation process, health outcomes, and eventual feelings of well-being and quality of life. These new resettled populations include voluntary and involuntary immigrants, as well as temporary or permanent residents with different values, expectations, and rules from the societies in their host countries. Some resettled groups have created new cultural communities, while others have added to existing residential communities. Both outcomes of resettlement have increased pressure on available societal services.

Culture-specific interventions have been developed and repeatedly reviewed in the United States, but these interventions have not been routinely incorporated into available therapeutic repertoires for these emergent populations. There are a number of reasons for this inattention: (a) preference for empirically supported culture-general interventions typically derived from research on mainstream population cultural orientations; (b) a managed-care emphasis on treatment of needs at a level of care associated only with medically necessary conditions; and (c) a belief that the development of culture-specific approaches is not feasible or cost effective. In the United States, these powerful disincentives have served to maintain the status quo within the behavioral health establishment. Nonetheless, this status quo will be disrupted in the early years of the current millennium as the United States reaches "critical mass" and becomes a genuine multicultural society, within the context of a globalization increasingly defined through other multicultural societies.

These new emergent populations require not just national, but also cross-national and international assistance to maintain and augment their humanity, as well as to foster their day-to-day functioning. Nonetheless, to date there has been no overarching conceptualization of the needs of these new groups as they face identity transformations and radically altered life circumstances. Nor have the resources required to

facilitate that occupational viability and personal functioning that would maximally contribute to continued global development been adequately identified, consensually accepted, or mobilized either by nations or multinational corporations. This new global order is still fragile, but resonant with intimations of a better life for greater numbers of people.

## Summary

The expanding populations discussed in this chapter move across national boundaries seeking work, freedom, and security. Their dislocations in time, place, and social position superimpose new identities on their national and cultural identities of origin. In an era of fluid environments in response to globalization and rapid social change, emergent groups each have different needs, vulnerabilities, and strengths. Different resources and interventions must be provided by nations and their employers. Alterations in their life circumstances have resulted in a need to tap hitherto unknown and unavailable societal resources encouraging employability, sustaining group integrity, and impacting personal functioning during unprecedented social change stimulated by global development.

This chapter suggests that the behavioral health and well-being of both elite and underclass multicultural populations can benefit from the economic globalization experience of international organizations, which provide a different model than that espoused by national behavioral health systems of care. The realm of possible environmental structures and management techniques identified and at times employed in international, multicultural corporations provide examples of a prevention and health promotion approach to health and well-being that contrasts with current systems of national behavioral health treatment for psychopathology. This work setting experience constitutes a novel resource for support of a multicultural workforce, and more broadly, the family and community systems and institutions of multicultural populations. National health care models can be supplemented through the immense network of existing relevant information on everything from preventive stress management tools to other workplace psychological interventions. On a group level, preventive stress management can reduce stressors, and strengthen resilience and resistance resources. On an individual level, it can simultaneously manage stress responses, generate and monitor *eustress*, and provide professional assistance in managing symptoms only when necessary (Quick & Tetrick, 2003). The caveat in promotion of this model pertains to questions regarding its generalizability from monocultural employee populations to an international, multicultural workforce. Transportability can only be accomplished following demonstration of cross-cultural equivalence of these preventive stress management and other prevention and health promotion intervention techniques, or their cultural adaptation and cultural reformulation in cases of nonequivalence.



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