Migrants and Refugees. Each year an estimated four million people travel illegally across national borders (Gushulak & MacPherson, 2000). In today's rapidly globalizing world, ever more people will relocate in search of opportunities to improve their lives or to escape intergroup conflict, environmental disasters, and economic and political oppression. The trend toward greater control over national borders has paradoxically increased the illegal movement of people. Such movement entails health risks to migrants and refugees. Although the health risks to migrants and refugees have not been studied systematically, descriptive accounts suggest that they are significant for this population as well as the population in the country of destination (Gushulak & MacPherson, 2000). These health risks range from minor to life threatening (e.g., HIV/AIDS) and are being examined within and across discrete stages of the migratory process: predeparture, the journey, and destination. Multidisciplinary experts have hypothesized a number of factors that may contribute to the health of migrants and refugees in these stages: Health conditions in the country of origin and social equity (e.g., poverty) bear upon the predeparture stage; type of transportation, environmental conditions, and psychosocial factors (e.g., violence) impact the journey; and barriers to social programs, acquired health problems, and noncommunicable diseases (e.g., sexual abuse) have relevance upon arrival. Several international foundations, such as TAMPEP, are mapping the demography and distribution of migrants and refugees in the sex industry in hopes of containing the international transmission of HIV/AIDS (Wallman, 2001). A global response to the health hazards of migration mandates a multidisciplinary and international effort at various levels (e.g., government agencies, scientific and professional organizations, individual experts) to recognize, define, measure, and address the biopsychosocial factors that impact the health of migrants and refugees. Among the most important challenges for psychologists is the assessment of the health of migrants and refugees, design of holistic interventions to arrest and prevent illness at different stages of migration, and evaluation of programs that provide care for sick migrants and refugees (Gushulak & MacPherson, 2000). Specific to HIV/AIDS among migrant and refugee sex workers, psychologists are developing streetwise and culturally appropriate information and approaches to education, networking with physicians and social service agencies, mediating between migrants and refugees and local authorities, and empowering migrant and refugee communities in order to prevent infection and promote sexual health (Wallman, 2001).

Mental Health

Although symptoms of psychopathology vary markedly worldwide (Draguns & Tanaka-Matsumi, 2003), thorny conceptual, definitional, and psychometric issues threaten the integrity of cross-cultural research on psychopathology. Likewise, it has proved difficult to identify the core and presumably universal dimensions of different forms of psychopathology. Epidemiological studies have found comparable incidence rates and symptom constellations for certain disorders across countries and cultures, especially for major depression and schizophrenia (Draguns & Tanaka-Matsumi, 2003). Depressed persons generally exhibit sadness, anhedonia, limited attention and concentration, low energy, poor self-esteem, and suicidal ideation, with guilt showing the greatest intercultural variation. Schizophrenia also has fairly similar incidence rates internationally and cross-culturally, and is manifested by confusion, lack of insight, blunted affect, delusions, hallucinations, ideas of reference, and the experience of control, with its onset and course varying according to a country's level of industrialization.

In addition to epidemiological research, psychologists are investigating whether cultural expressions of psychopathology become more or less variable as symptom severity increases, if elements of certain cultures induce psychopathology (e.g., eating disorders in Western nations), and how massive changes introduced by globalization impact the form and level of psychopathology worldwide (Draguns & Tanaka-Matsumi, 2003). Draguns and Tanaka-Matsumi (2003) pursue a research agenda that articulates a potential connection between psychopathological symptoms and cultural characteristics, derived from Hofstede's (2001) five cultural dimensions (i.e., individualism–collectivism, power distance, masculinity–femininity, uncertainty avoidance, and dynamism orientation), although these dichotomies have been questioned in view of the increased cultural complexity and heterogeneity engendered by globalization (Hermans & Kempen, 1998).

Approaches to the remediation and prevention of psychological suffering around the globe increasingly entail interventions that do not originate in reductionistic psychology (Gielen, Fish, & Draguns, 2004; Stevens & Wedding, 2004a). Psychologists have discovered that imported psychotherapeutic models and methods are not equally applicable within different cultural, economic, historical, political, religious, and social contexts and must, therefore, be substantially modified (e.g., the use of action

research to identify local factors that contribute to resilience and can form the basis for culturally meaningful and beneficial mental health services). These transformations often assume a relationship between mental health, human rights, and the struggle against injustice. Many Latin American psychologists, for example, construe mental illness as a reasonable accommodation to oppressive forces, such as discrimination, poverty, and trauma, rather than as caused by organic and intrapsychic disregulation (Comas-Díaz, Lykes, & Alarcón, 1998). Consequently, these practitioners eschew medication management and corrective therapies (e.g., behavior modification) in favor of approaches that target social injustice and involve activism and advocacy.

Psychologists worldwide are devising procedures that match the lives of people they seek to help, such as bearing witness and attitudinal healing. These approaches are used to raise individual and collective awareness of how oppression impacts mental health and to transform alienation and despair into affirmation, solidarity, and empowerment; it is assumed that contexts producing suffering may also contribute to recovery, and that those who have been victimized may become agents of contextual change (Wessells, 2000). Ethnopolitical psychotherapy is an eclectic approach whose goals are to enhance people's capacity to analyze the causes and consequences of their position within society and undertake transformative action individually and collectively (Comas-Díaz et al., 1998). Ethnopolitical psychotherapy has been utilized in indigenous communities in Guatemala that report distrust, weakened traditional values, and fear of violence after decades of civil unrest (Martin Beristain, Gonzalez, & Paez, 1999). Bearing witness to survivors' testimony of trauma and loss facilitates individual and collective recovery and supports community mobilization for accurate institutional memory and justice. The Association St. Camille de Lellis, a Catholic charity for the mentally ill, operates a community program built upon the economic, sociopolitical, and cultural realities in the Côte d'Ivoire (Morin, Attoungbre, & Dallaire, 2002). The program empowers people through narrative procedures to assume greater responsibility for themselves and also strengthens local resources and networks that support interdependence. Other community-oriented interventions that offer support and cultivate interpersonal bonds are employed in collectivistic nations, such as Japan, to prevent depression in workers (Katauke & Shoji, 2000).

Before examining the mental health concerns of women, children and adolescents, and migrants and refugees, it is important to note the growing synthesis of traditional healing and modern therapies in industrialized and less developed parts of the world. This synthesis comes from a growing recognition of the salience of indigenous representations of mental illness and health—as opposed to Western approaches—and explains their limited success when introduced in different cultural contexts. For example, folk and modern psychological treatment have been successfully integrated in the mental health services offered to ethnic Turks residing in Germany (Assion, Dana, & Heinemann, 1999).

Women. Researchers have consistently found that the incidence of depression among women is twice that of men, with the ratio between men and women for major depression at approximately 1:4 (Draguns & Tanaka-Matsumi, 2003). Aside from their greater willingness to acknowledge symptoms and seek treatment, psychologists have attributed the gender difference in depression to the fact that women are socialized into less powerful and lower status roles and, hence, have harsher economic and social lives and fewer opportunities to improve their lot. Of particular interest is the proposed link between violence against women and their report of depression. It is not uncommon to learn via the media of the global traffic in women and cases of female genital mutilation and honor killing in conservative, male-dominated countries. Entire communities of women have been raped and traumatized in the course of ethnic conflict, as occurred in Bosnia-Herzegovina, Rwanda, and Sudan. Globally, one third of women have been beaten, raped, and/or abused psychologically within intimate relationships (Murphy, 2003). Added to the physical harm and injury, domestic violence increases women's risk for depression, substance abuse, and suicide. International and cross-cultural variability notwithstanding, domestic violence appears tied to the interaction of cognitive (e.g., asymmetrical gender roles, implicit theories that accept interpersonal violence) and ecological (e.g., conservative religious values, weak political and civil institutions) factors (Malley-Morrison, 2004). In Russia, the incidence of domestic violence covaries with indicators of national economic and political stability. The rates of domestic violence and teenage prostitution in Israel tend to increase during economic downturns and political violence. Buoyed by the recommendations of the International Conference on Population and Development for integrative interventions to combat all violence against women everywhere (Malley-Morrison, 2004; Murphy, 2003), psychologists serve on multidisciplinary teams that design ecological programs to heal and empower battered women, improve batterers' emotional regulation and verbal communication, and re-socialize families whose implicit theories favor violence (Haesevoets, 2003).

Children and Adolescents. Tragically, upwards of 300,000 children and adolescents in over 80 countries have been recruited or forced to engage in violent conflicts (Parson, 2000). Some volunteer, seeking revenge upon their enemies, martyrdom, or economic viability. Others are coerced and/or manipulated to serve and remain in militias and other armed groups. While serving as cooks, laborers, prostitutes, spies, guards, and fighters, these youth experience and witness extreme violence, including the murder of family members and friends, and the destruction of their homes and communities. Children and adolescents, who reside in places that experience intractable conflict like the Middle East, are exposed daily to such violence. The psychological sequelae of exposure to violent conflict include acute and posttraumatic stress disorders, mood disorders, externalizing and disruptive behaviors, and somatic complaints as well as changed developmental trajectories (Aptekar, 2004; Parson, 2000). Research is underway to identify variables that exacerbate or insulate the psychological effects of exposure to violent conflict, including the level and duration of exposure, gender, personal resources, and family and community factors. For example, the degree to which Palestinian children participate in the Intifada is positively correlated with deficits in attention, memory, and self-esteem; however, some of these children appear to be buffered from exposure to violence by psychological flexibility (Qouta, El-Sarraj, & Punamaeki, 2001). These findings, coupled with cross-cultural research on how youngsters cope and develop (Aptekar, 2004; Frydenberg et al., 2003), can lead to more effective and efficient remedial and preventive interventions for at-risk children and adolescents.

Globally oriented psychologists have become part of the multidisciplinary and multi-layered process of post-conflict reconstruction (Wessells & Monteiro, 2004). In addition to healing psychological wounds, psychologists assist children and adolescents associated with violent conflict in becoming reintegrated within mainstream society. Often, those who participate in violent conflict, regardless of whether their involvement was involuntary or peripheral, experience discrimination and marginalization. These youngsters may be barred from returning to school and, consequently, may join groups of other ostracized peers whose hopelessness and resentment fuel antisocial violence. Psychologists have partnered with governments, relief agencies, and local leaders to forge programs that meld psychological with cultural, political, and spiritual elements in order to salvage shattered lives. Specific interventions that must be tailored to impoverished and unsafe conditions include reconstituting families, education and vocational training, supporting adults and caregivers, and strengthening the capacity of communities to build a better future (Wessells & Monteiro, 2004).

Migrants and Refugees. Finally, there is a burgeoning literature on the acculturative stress of migrants and refugees especially in Europe, owing to the fall of communism and emergence of the European Union, and in Canada, whose social policies invite relocation there. Psychological and somatic indicators of the acculturative stress of migrants and refugees appear inversely related to psychological hardiness, positive attitudes toward acculturation, social support within the family and emigrant community, language proficiency, level of participation in the host society, and the absence of discrimination (Miller & Rasco, 2004). Other studies have reported that self-esteem buffers migrants and refugees from the adverse psychosocial impact of discrimination, with parental support and traditional values contributing to self-esteem (e.g., Jasinskaja-Lahti & Liebkind, 2001). Psychologists have also proposed theoretical frameworks to explain the acculturative adjustment of migrants and refugees (Schmitz, 2003). The Interactive Acculturation model predicts cooperative or conflictual relations between migrants and refugees and members of their host community based on the interaction of complementary or opposing acculturative orientations held by these groups (Bourhis, Moiese, Perreault, & Senecal, 1997). Lastly, given evidence that discrimination stigmatizes migrants and refugees and intensifies their perception of and anger at being structurally disadvantaged, European psychologists are formulating a pluralistic, rather than an integrative model for social cohesion in which different ethnic constituencies are ensured equal access to political participation and encouraged to preserve their distinct cultural identity (Bilbeny, 2003).

CONCLUSION

This orientation began with a definition of global psychology, and a cautionary note that the term *global* is more inclusive than *international* and that both terms should be used judiciously given their nuances. The mission of global psychology is to promote communication and collaboration among psychologists worldwide via scholarship, advocacy, the curriculum, and networking. Global psychology can be distinguished from the cross-cultural psychology and ethnic studies, and has links to two specialties that are relatively unfamiliar to psychologists in the United States: economic psychology and political psychology. The orientation also surveyed

the recent English and non-English language literature on three intersecting global concerns that are relevant to scientific and applied psychology in the industrialized and less developed worlds: intergroup conflict, threats to the natural environment, and risks to physical and mental health, particularly among women, children and adolescents, and migrants and refugees. Throughout this survey, I underscored the need for and value of approaching these concerns from reductionistic as well as through alternative perspectives (see part II, chapters 2–5) and from a multidisciplinary, multi-layered, and contextually sensitive foundation of knowledge and skill (see part III, chapters 6 through 11).

As its editors, we hope that *Toward a Global Psychology: Theory, Research, Intervention, and Pedagogy* will equip readers to engage their counterparts worldwide as researchers, practitioners, and trainers (see part IV, chapter 12). We further hope that readers will become more involved globally, joining or establishing collegial networks to address in innovative ways the urgent global concerns described earlier. Increased involvement and openness to dialogue will reflect an expanding vista that invites all psychologists to pursue a psychology that is more unified, meaningful, and socially responsible.

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