Working in a Multicultural Society: Challenges for the Norwegian Psychologist

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Traditionally, psychology has assumed the existence of a gold standard – an appropriate way of behaving – against which all others are measured. Unfortunately these theories have been developed among middle class white college students who differ substantially from the large majority of the societies they serve.

Over the last few decades, the relatively culturally homogenous Norwegian society has become more pluralistic as the result of a high immigration of foreign nationals into the country. While there were approximately 59 000 foreigners living in Norway in 1970, constituting about 1.5 % of the national population, this number and percentage had increased approximately sixfold to 365 000 and 7.9 % respectively in 2004 (SSB, 2005). There are currently foreigners from ca. 200 national countries living in Norway, making the country as ethnically diverse as the United Kingdom in terms of the percentage of foreign born to the total population (Migration Information Source, 2005).

A culturally and ethnically diverse society poses a number of challenges to both politicians, local communities, helping agencies and practitioners such as social workers and psychologists. The focus of this article is to discuss from a generalist position some of the challenges a multicultural society poses to psychologists. Specifically, the article does this in two ways by (a) providing a broad theoretical position to the need for including a cultural perspective to the understanding of human behavior, and (b) illustrating this theoretical position with examples from my idiosyncratic research background: human development, and cross-cultural health and acculturation psychologies. It should be noted that the examples used in the paper are simply meant to give the psychologist an idea of what these challenges are, and, depending on the background and sub-discipline, the psychologist can develop specific ways of working appropriately in a multicultural society.

It is not uncommon for people in ethnically diverse communities to express concerns over the presence of foreigners of different cultural backgrounds – concerns over the loss of the original cultural values of the society (Sam & Berry, 2006). Part of these concerns is the desire that when people migrate they ought to give up their cultural baggage and take on the norms, values and traditions of the new society, i.e., to become assimilated (Brox, 1991). The underlying assumption is that assimilated immigrants would result in a harmonious society with shared and common cultural values (Gordon, 1964). It has, however, been argued that the assimilation assumption is both naive and potentially dangerous (Palmer & Laungani, 1999). It is naive because assimilation is not as tenable as previously assumed (Alba & Nee, 1997), and potentially dangerous because such

expectations may infringe on fundamental human rights. Such wishes may be ethnocentric as they rest on the assumption that the norms and values of the host society are better than those of the foreigner/ immigrant. As Palmer and Laungani (1999) further argue, no single country or culture can claim a privileged right to set up a gold standard of norms that the rest of the world has to follow.

People are normally deeply rooted in their cultures, and these roots extend over several generations. Thus, when people migrate, not only do they bring with them their skills, qualifications and experiences, but they also bring with them their unique way of thinking and behaving, their cultural beliefs, values and traditions, their religious practices, their rites, rituals and ceremonies, their family structures and their language. In essence the cultures immigrants bring with them are not easy to give up. In spite of these challenges, meeting of cultures provides opportunities to scholars and a host of care providers to learn and acquire insights into a variety of multicultural issues and to better understanding of human behavior and its diversity as questions such as these are asked, How do people from different cultures bring up their children? What are their moral values and how do these differ from ours? What constitutes child abuse? What are their attitudes towards women? What do they consider healthy, how will they respond to a particular therapy, and in what ways do their values impinge on the values of the new society?

Traditionally, the study of psychology and its practice has assumed the existence of a gold standard – an appropriate way of behaving – against which all others are measured. Unfortunately this assumed way of appropriate behavior is predominantly based on theories developed in Western industrialized societies. Worse still, these theories have been developed among middle class white college students (Jahoda, 1970) who differ substantially from the large majority of the societies they serve. Because people differ culturally, it may be harmful to indiscriminately impose someone else's way of behavior on others.

Working in a Culturally Plural Society

Working in culturally plural societies calls for a multidisciplinary and interdisciplinary approach to the understanding of human behavior. This requires, among other things, drawing upon theories, research and praxes from other subject areas such as anthropology, ethnography and sociology. This article draws primarily on some assumptions in cultural and cross-cultural psychology and links these to health psychology life-span human development.

The field of cross-cultural psychology has generally been divided into two related domains. One domain – the cultural domain – focuses on how cultural factors influence various aspects of human behavior (Berry, Poortinga, Dasen & Segall, 2002). This aspect of cross-cultural psychology has taken place around the globe (i.e., internationally), driven by the need to understand individuals in the context of the indigenous cultures of the people being examined and served. The second domain, i.e., the ethnic domain, is concerned with individuals and groups as they settle into, and adapt to, new cultural circumstances, as a result of their migration, and the persistence of their original cultures in the form of ethnicity. This enterprise has taken place in culturally plural societies (i.e., domestically) where there is the need to understand and better serve an increasingly diverse population in multicultural societies (Sam & Berry, 2006). Despite the division between the cultural and ethnic domains, it is a common position that the methods, theories and findings derived from the international enterprise should inform the domestic enterprise. That is, immigrants and members of the ethnic communities should be understood and served in culturally informed ways.

The above conceptualization is summarized in Figure 1, where the two areas of interest – the cultural and the ethnic domain – are respectively shown to the left and the right side of the figure with an arrow pointing from the left side (international or cultural domain) to the right side (domestic – ethnic domain). The arrow is to indicate that the acquired knowledge from working internationally and culturally should inform the ethnic and domestic work. Both the cultural and the ethnic domain has certain features: theoretical orientations and conceptions of behavior (in the case of the cultural domain) and conception of ethnicity, acculturative stress and multicultural services) that characterize and guide work within the two domains. In the next sections we will briefly describe and exemplify these features.

Figure 1. The cultural and ethnic domains. The acquired knowledge from working internationally and culturally should inform the ethnic and domestic work

The Cultural Domain

There are three main theoretical positions within the cultural domain that are concerned with how human behavior is to be understood. In deed the appropriate way of studying human behavior has been a debatable issue for centuries, dating back to the Greek philosophers. One side of the debate

was laid down by Aristotle when he suggested that it is possible to study human behavior devoid of culture and the influences of ones surroundings. Protagoras, on the other hand, suggested that the conceptions and explanations that we generate about ourselves are intricately linked to our own experiences. These two views have entered psychology by way of two basic assumptions, and have directed psychological research. The central question is whether in explaining psychological processes we assume the existence of substantial commonalties in the psychological makeup (i.e., the *psychic unity*) of human beings, and commonalties in human experience and behavior (i.e., *psychological universals*). Or whether we assume that it is impossible to study people in vacuums, and that behavior can best be understood in the context in which it occurs. The latter assumption is that behavior occurs within certain social environments or cultural contexts, and these need to be taken into consideration when studying human behavior.

When these two broad perspectives are dichotomized into a «yes» and a «no», and simultaneously dealt with in an orthogonal manner, four competing perspectives in psychological inquiry arise: *human uniqueness (*i.e., a «no» to both perspectives), *absolutism* (i.e., a «yes» to psychic unity and psychological universal, and a «no» social environment*), relativism* (i.e., a «yes» to social environment and a «no» to psychic unity and psychological universals) and *universalism* (i.e., a yes to both perspectives) (Adamopoulus & Lonner, 1994; Sam, 1997).

Human uniqueness: This perspective arises when psychological inquiry assumes that it is irrelevant to look for commonalities in human behavior, and that the cultural context in which behavior occurs is irrelevant. This assumption focuses entirely on the uniqueness of individuals, and leads to an orientation that may be incompatible with science, i.e., the essence of science to focus on systematic explanation of patterns or events or occurrences. Within this position, observed variations are considered neither to have a common base to warrant the search for a systematic explanation, nor to warrant the formulation of generalized theories in view of the uniqueness of every human behavior. While this position might be regarded as limited for scientific purposes because it is difficult to make generalizations, it might characterize the position taken by an existential clinical psychologist.

Absolutism: This perspective may be said to be represented by the mainstream orientation in modern psychology and assumes the existence of a gold standard. It rests on the broad principle of *psychic unity* that assumes that there is an underlying common (true) nature to all human beings that can be identified, described and used to explain the product of their behavior. The fundamental assumption about the possibility of absolute truths is the reason for this position being referred to as

absolutism (Berry et al., 2002). The assumption is that if we eliminate culture and the environmental factors such as norms, values, ideologies etc., we will be able to find what is common for humanity, or the true human psyche. In other words, intelligence is intelligence, honesty is honesty, and so is aggression, aggression irrespective of who or where it is studied. This position may argue that all human behavior is essentially the same, and may just be masked by variations in language and superficial features such as clothing (or more precisely culture).

Methodologically, this perspective tends to undertake comparisons in human behavior to understand the underlying psychological principles. In undertaking such comparisons, standardized instruments are used. Observed psychological differences tend to be registered quantitatively, where, for instance, this perspective will report some people to be less intelligent or more depressed, based on scores on some instruments.

A problem inherent in making comparisons in psychology is the danger of drawing ethnocentrically based conclusions when differences are observed. One such conclusion was the earlier belief that depression was unknown among Africans (see Littlewood & Lipsedge, 1989). The desire to overcome making ethnocentric conclusions delineates the fundamental stand of the relativist perspective.

Relativism is a perspective often associated with the anthropologist Herkovits (1948), although the ideas underlying this perspective originated from B oas (1911). Relativism seeks to avoid all traces of ethnocentrism by trying to understand people *in their own terms* without imposing any value judgments or *a priori* judgments of any kind. It therefore seeks to avoid derogating other peoples, as well as to avoid describing, categorizing, and understanding others from an external cultural viewpoint. The phrase *in their own terms* thus means both *in their own categories* and *with their own values* (Berry et al., 2002). There is the working assumption that explanations of psychological variations across the world's people are to be sought in terms of cultural variation with little recourse to other factors. The relativist position is strengthened by mainstream psychology's inability to account for culture-bound syndromes such as *latah* (Tseng, 2000).

Theoretically, relativists do not show much interest in the existence of similarities across cultures, except to assume a general egalitarian stance (e.g., *all people are equal*), and to explain any differences that they may observe as being due to cultural contexts influencing an individual's development. Differences are interpreted qualitatively: e.g., people have equal intellectual capacities,

but they differ in the styles they express them. This position naturally avoids comparative studies, because they are both problematic and ethnocentric, and render valid comparison impossible.

Universalism: Psychologists who align themselves with this perspective are concerned about the dynamic interaction between human beings and their environment. The working assumption of this position is that basic psychological processes are likely to be common features of human life everywhere, but that their manifestations are most likely influenced by culture. In short, variations in human behavior are due to «culture» playing different variations on a common theme (representing the psychic unity). Methodologically, both qualitative and quantitative methods are employed. However, before standardized instruments are used, they are subjected to rigorous examination to ascertain their appropriateness. Comparisons are normally undertaken, but cautiously carried out. Stated in another way, comparisons are neither avoided (as in the case of relativism) nor carried out with whim (as in the case of absolutism). Universalism is a perspective often ascribed to cross-cultural psychologists[1].

While all the theoretical orientations may have its adherents, working in culturally plural societies calls for either a relativist and/or universalist stance as these positions acknowledge the importance of culture in the expression of human behavior.

Conceptions of Behavior from a Cultural Perspective

In the next two sections we will illustrate how behavior, with reference to health beliefs and behavior, and human development, may be conceptualized from a cultural perspective.

Health beliefs and behavior: One can normally speak of four categories of behavioral phenomena (i.e., affective, cognitive, behavioral and social), and two levels of analyses (community/ cultural and individual/psychological). At the community level one can explore health conceptions and definition; health norms and values; health practices and health roles and institutions with

[1]Id=”fag-sam-81”> From a cross-cultural psychological view point universalism is a term reserved for theories that have been examined and proven to be valid in different cultural groups and societies and not ones simply assumed to be so. Theories that are assumed to be valid across cultures and societies but have not been examined for such generality are referred to as absolutism from a cross-cultural perspective.

reference to the cognitive, affective, behavioral and social categories of behavior respectively. Similarly, at the individual (psychological) level one can explore health knowledge and beliefs, health attitudes, health behaviors and interpersonal relationships respectively in the four categories of behavior (i.e., affective, cognitive, behavior and social). Together these produce eight areas in which information can be sought during the study of links between culture and health (Table 1). The community level of work typically involves ethnographic methods to study the culture, and yields a general characterization of shared behavioral concepts, values, practices, and institutions in a society.

Table 1. Eight Areas of Interest in the Relationship Between Culture and Individual Health

	Categories of Health Phenomena			
Levels of Analysis	Cognitive	Affective	Behavioural	Social
Community (Cultural)	Health Conceptions and Definitions	Health Norms and Values	Health Practices	Health Roles & Institutions
Individual (Psychological)	Health Knowledge and Beliefs	Health Attitudes	Health Behaviours	Interpersonal Relationships

The individual level of work involves the psychological study of a sample of individuals from the society and yields information about individual differences (and similarities), which can lead to inferences about the psychological underpinnings of individual beliefs, attitudes, behaviors and relationships.

The reason for taking cultural level phenomena into account is that without an understanding of this background context, attempts to deal with individuals and their behavior may be fruitless. The reason for considering individual level phenomena is that not all persons hold the same beliefs or attitudes, nor do they engage in the same behaviors and relationships; without an understanding of their individual variations from the general community situation, harm may be inflicted (Berry, 1997a; Berry & Sam, in press).

At the cultural level the way in which a cultural group defines what is health and what is not can vary substantially from group to group. These collective cognitive phenomena include shared conceptions and categories, as well as definitions of health and disease. At the individual level, health beliefs and knowledge, while influenced by the cultural conceptions, can also vary from person to person. Beliefs about the causes of an illness or disability, or about how much control one has over it (both contracting it and curing it), shows variations across individuals and cultures. For example, some cultures classify their food in terms of «hot» and «cold», and what they eat when they fall sick

also depends on whether the sickness is defined as «hot» or «cold» (Helman, 2000). In the fishing villages that line Lake Victoria in East Africa, the parasitic disease schistosomiasis is so prevalent that the bloody urine of young males during the full-bloom stage of the disease is considered a healthy sign of approaching manhood. There is no reason to seek medical attention for this ailment (Desowitz, 1981).

With respect to affective phenomena, the value placed on health is known to vary from culture to culture and within cultures across subgroups. Pain, in one form or the other, is an inseparable part of everyday life, yet not all social or cultural groups may respond to pain in exactly the same way. How people perceive and respond to pain, both in themselves and in others, is influenced by their cultural and social background (Helman, 2000).

Health practices and behaviors also vary across cultures and individuals. For example, with respect to nutrition (Dasen & Super, 1998), what is classified as suitable food, and who can eat it, are matters of cultural practice. Many high protein «foods» are not placed in the food category (e.g. brains) and are avoided, while in other cultures they are an important part of the diet. Within these general cultural practices, however, individuals vary in what they can eat, depending on age, status, or food factors related to clan membership.

The social organization of health activities into instructions, and the allocation of roles (e.g. healer, patient), also vary across cultures. In some cultures religious or gender issues affect the role of healer (e.g. only those with certain spiritual qualities, or only males, may become a healer), while in others the high cost of medical or other health professional training limits the roles to the wealthy. In some cultures health services are widely available and fully integrated into the fabric of community life (e.g. Aversasturi, 1988), while in others doctors and hospitals are remote, mysterious and alien to most of the population. In the former case individual patient-healer relationships may be collegial, in which a partnership is established to regain health, while in the latter the relationship is likely to be hierarchical, involving the use of authority and compliance.

Human development – Parental ethnotheories: From a cross-cultural psychological perspective human development is seen as an adaptation to different ecological and environmental demands (Whiting & Whiting, 1973, 1975), and developmental goals guide cultural practices of child care and parenting. LeVine (1977) proposed a universal hierarchy of parental goals with survival and health as the foundation, followed by goals relating to economic independence, and, finally, goals related to the cultural definition of the personality. Systems of developmental goals and values that

guide child rearing and socialization for particular parents and groups of parents are called parental ethnotheories of development (Greenfield, Keller, Maynard & Suzuki, 2004). This is a system of beliefs and ideas concerning the nature of the ideal child and the socialization practices necessary to achieve this ideal (Goodknow, 1988, Harkness & Super, 1996; Super & Harkness, 1997).

Research over the last decade has suggested the existence of two broad idealized developmental trajectories that link together differences in cultural learning throughout development. While one developmental pathway emphasizes individuation and independence, the other emphasizes group membership and interdependence. Each ideal is part of a larger sociocultural system: the first termed individualistic and the latter collectivistic (Hofstede, 1980; Triandis, 1990) cultural construction of the self as independent and interdependent respectively (Markus & Kitayama, 1991). According to this model adult conceptions of the ideal and actual self also serve as developmental goals that organize socialization experiences in characteristic ways (Kagitcibasi, 1990, 1996, 1997). The extent to which societies endorse these two developmental trajectories vary, and it is not an issue of «either-or» endorsement. For the purposes of this discussion, however, we portray them as two broad categories.

The conception of developmental pathway implies a coherent and meaningful organization of the developmental tasks over the life span. The solution of earlier tasks along the pathway forms the foundation for later steps along the same pathway (Greenfield, Keller, Fuligni & Maynard, 2003).

Three universal tasks that all humans have to go through are *relationship formation*, *knowledge acquisition*, and *autonomy-relatedness*. Each of these tasks first becomes important at different developmental phase: relationship formation during birth, knowledge acquisition during early childhood, and autonomy/relatedness during adolescence. These universal tasks are dealt with differently depending on the developmental pathway (i.e., interdependence or independence) endorsed by the cultural group.

Because of their extreme helplessness infants are dependent on a care-giving environment for their survival. This is achieved through a social relationship which not only prepares the child for the cultural environment, but also sets the stage for later developmental tasks. The core theoretical approach to relationship formation is the attachment theory (Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1969). However, studies have shown that the underlying assumptions of attachment theory are geared towards an independent cultural orientation (Rothbaum, Weisez, Pott, Miyake & Morelli, 2000). For instance, secured attachment as assessed through strange situations evaluates

the infant's behavior after separation from the mother. Attachment is measured by how the child reconnects with the mother after the separation. However, mothers in non-Western cultures do not treat the baby's desire for proximity in the same way as in western cultures. Moreover, «strangers» in the United States are less strange and more familiar to babies than they would be in other parts of the world. In non-Western cultures, where interdependence is of high value, parental ethnotheory is one of continuously close mother-child relationship involving close body contact through carrying throughout the day and sharing bed during the night (Scheper-Hughes, 1986; Super & Harkness, 1997). In cultural communities where independence is of high value, an ethnotheory of early infant independent function is enforced. Among other things children are expected to sleep through the night, and often in a separate bed and a separate room.

Knowledge acquisition in Western thought is based on Piagetian cognitive development. The body of theory and research with respect to knowledge acquisition in Western thought gives high importance to scientific intelligence as a developmental goal. The goal is fundamental in societies that place high value on independent mode of social relations (Greenfield et al., 2003). The goal of scientific intelligence belongs to the individualistic pathway as it emphasizes the person in relationship to the world of objects. As Greenfield et al. (2003) put it, «this goal for the development of intelligence is compatible with infant care giving practices that emphasize leaving the child alone to manipulate technologically appealing toys» (p. 472). In societies that value interdependence as a developmental pathway, emphasis on social intelligence is the norm (see Dasen, 1984; Mundy-Castle, 1974, Sepell, 1993). For instance, the central feature of intelligence among the Boulé tribesmen in the Ivory Coast is willingness to help others (Dasen, 1984). The stages of human development among West African children are defined in terms of social roles (Nsamenang, 1992). African cultures not only emphasize social intelligence, but also see technical skills as means to social ends (Dasen, 1984).

As a child enters into adolescence, it is expected to be no longer wholly dependent on other family members for care and survival, but to take on an adult-like role and contribute towards the well-being of others. For parents, this involves finding a balance between autonomy and relatedness or individuation and connectedness (i.e., a situation that provides the child with the opportunity to develop the ability to think and act independently within the context of supportive relationships with parents). Studies have nevertheless indicated that the universal developmental goal varies across cultures in the manner and the extent to which each dimension is emphasized, expected and granted across societies and ethnic groups. These variations can be seen in such areas of life as behavioral

autonomy and parental control, and familial duty and obligation. For example, a number of studies have shown that European American parents more likely than other parents engage in authoritative parenting, which emphasizes the development of autonomy and self-direction within the context of a warm supportive relationship. In Asian American and African American families parents tend to engage in authoritarian parenting, which focuses on obedience and conformity among children. The two forms of parenting styles – authoritative and authoritarian – are compatible with independent and interdependent developmental pathways respectively (Green-field et al., 2003).

While different cultural societies emphasize different developmental pathways, and use different means to ensure these goals, the underlying ethnotheories will vary across cultural societies, depending on individual backgrounds such as socioeconomic state.

The bulk of research in human development rests on parental ethnothories that are consistent with an independent developmental pathway, and this line of research rests on the assumption of *absolute truth* (i.e., absolutism). This theoretical assumption does not have room for cultural thinking. The implications of these for psychologists working in plural societies are discussed under the ethnic domain.

Ethnic Domain

When we focus on the behaviors of culturally distinct groups and individuals, who live in culturally plural societies, we are dealing with the ethnic domain (Berry, 1997a).

While ethnic groups are not full-scale or independent cultural groups, it is a working belief of cross-cultural psychology that all the methodological, theoretical and substantive lessons learned from working with cultural groups in the international enterprise should inform our work with ethnic groups. That is, there is the need to know about the community's health and behavioral conceptions, values, practices and institutions of the ethnic group, and about how these are distributed as beliefs, attitudes, behaviors and interpersonal relationships among individual members of the group. Stated in another way, we are not dealing with «minorities» that are simply deviant from some «mainstream», who need to change their values and traditions in order to be assimilated into the larger society. Ethnic groups belong to communities that deserve to have their behavioral lifestyles, childrearing styles and goals, their health and health needs understood. Thus, work in the ethnic domain does not differ in principle from work in the cultural domain. However, there is an added element, namely contact and

possibly conflict, between cultural groups. This is the case in a number of respects: first, the health phenomena of ethnic individuals and their developmental pathways may be quite different from those of the larger society, and these differences may create misunderstanding, confusion and conflict between the two groups. Secondly, these conflicts may themselves generate new health problems; and thirdly, the health services of the larger society may not be sufficiently informed, or sensitive, to enable them to deal with either the health problems that are linked to the heritage of the ethnic group, or those that have their roots in the conflict between the two groups in contact (Sam & Berry, 2006).

Since the first of these issues is very similar to the discussion of the cultural domain, it will not be pursued further here. However, there is one important difference. When a health professional does not understand an individual's health needs while practicing in another country, at least the individual may have recourse to an indigenous health system. When this lack of understanding occurs with respect to an ethnic individual, there may no longer be such an alternative service of health support. The second and third issues can be considered using the notions of acculturative stress, and multicultural health.

Acculturative Stress

In the literature on the health and well-being of ethnic groups and individuals, there was an earlier assumption that the experience of culture contact and change will always be stressful, and lead to loss of health status. As is the case for other forms of stress, this assumption is no longer supported; to understand why there are variable outcomes to culture contact, the notions of acculturation strategies need to be introduced.

In broad terms acculturation refers to all the changes that occur when individuals and groups of different cultural background come together. In our present discussion it refers to meeting between immigrants and members of the host society, which in essence requires individual members of both the larger society and immigrants to work out new forms of relationships in their daily lives. Intercultural group contact as it prevails in plural societies can bring to light differences in developmental pathways and the underlying ethnotheories to achieve these goals. Often the developmental pathway of the larger and dominant society is taken for granted and assumed to be the norm for everyone. Intergroup contacts raise ethnic identity awareness (Phinney, 1990), and bring to the fore developmental issues of ethnic self-awareness.

One of the findings of much subsequent research in the area of acculturation is that there are vast individual differences in how people attempt to deal with acculturative change (termed

«acculturation strategies»; see Berry, 2003; Sam & Berry, 2006). These strategies have three aspects. Their preferences («acculturation attitudes»); how much change they actually undergo («behavioral shifts»); and how much of a problem these changes are to them (i.e., the phenomenon of «acculturative stress»; see Sam & Berry, 2006).

Perhaps the most useful way to identify the various orientations individuals may have toward acculturation is to note that two issues predominate in the daily life of most acculturating individuals. One pertains to the maintenance and development of one's ethnic distinctiveness in society, in which people decide how much their own cultural identity and customs are of value and should be retained. The other issue involves the desirability of interethnic contact, in which people decide whether relations with other groups in the larger society are of value and should be sought. When these two issues are dealt with simultaneously, four ways of dealing with acculturation – acculturation strategies – (i.e., assimilation, integration, separation and marginalization) may be identified. For detailed discussion of these strategies, see Sam and Berry (2006).

Inconsistencies and conflicts between various acculturation strategies form one of many sources of difficulty for acculturating individuals. And different acculturation strategy may entail different lifestyles and health outcome (Berry & Sam, 1997). Generally, when acculturation experiences cause problems for acculturating individuals, we observe increased levels of acculturative stress. In an overview of this area of research (Berry, 1997b) it was argued that stress may arise, but it is not inevitable.

From the developmental perspective a family with an interdependent developmental pathway raising a child in a society that values an independent developmental pathway is likely to experience some conflicts. For instance, in the United States teachers focus on independent academic achievements, whereas Latino parents are often more concerned about social behavior (Greenfield, 2000).

Research in a number of countries has typically revealed variations in, but sometimes no greater mental health problems among, ethnic groups than in the general population (Beiser et al., 1988). However, stress is usually lower when: integration is being sought (but is highest for marginalization); migration was voluntary (i.e. for immigrants) rather than forced (i.e. for refugees); there is a functioning social support group (i.e. an ethnic community willing to assist during the settlement process); and when tolerance for diversity and ethnic attitudes in the larger society is positive (Berry, 1997b).

In summary, the behavioral outcome of acculturating individuals is highly variable, and depends on a variety of factors that may be under the control of policy makers. Stress, with resultant poor health, can be avoided by implementing some social policies. One of these, to which we now turn, is the development of a pluralist case system, one that is knowledgeable about and sensitive to the needs of ethnic groups and individuals.

Multicultural Services

The area of multicultural services primarily involves research, training and action directed toward improving the level of understanding and the quality of services available to ethnic groups and individuals who now live in culturally plural societies. The research component is driven by the work in the cultural domain, and on acculturative stress, and should result in better understanding of the health and behavior of ethnic groups. It is unethical to presume to provide health and social services to people we do not understand. Essentially, what this means is that it behoves service providers such as psychologists to secure culturally informed ways of working when living in a culturally plural society. It is naïve and ethnocentric to assume that the knowledge acquired from serving a particular ethnic or cultural group suffices when catering to other cultural and ethnic groups. It is important that members of culturally plural societies are trained and schooled in subject areas (e.g., geography, history, political science, moral philosophy, etc) that reflect the ethnic composition of the society rather than simply limiting the training and schooling to issues relevant only for the larger society.

The action component is directed towards changing the social institutions of the larger society, and the beliefs, attitudes, behaviors and relationships of members of the larger society with respect to these issues. This is the same framework employed earlier to outline areas of interest in the relationship between culture and health which can guide the actions that are required. This may entail, among other things, removing social structures (e.g., the educational system) that prevent the acquisition of cultural knowledge of other ethnic groups. It may also entail recruiting service providers in order to reflect the ethnic composition of the society being served.

Conclusions

This article has looked at the challenges that psychologists working in culturally plural societies may face, using examples from cross-cultural perspectives in life-span human development and health psychology. But the issues raised here in reality permeate an entire society and are not limited

to the health sector only. Indeed the issues are equally relevant for psychologists working in all sectors of the society, be it in an organization, a school or the health sector. Acknowledging that culture influences human behavior «implies that there is not one (normative) conception of health and psychological wellbeing» (Greenfield et al., 2003, p. 571). The definition of healthy development, or appropriate behavior for that matter, is relative to the cultural society, and will vary from society to society, and for ethnic groups living in a multicultural society.

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