THE IMPLICATIONS OF CULTURE SHOCK FOR HEALTH EDUCATORS: REFLECTIONS WITH BARER-STEIN

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ABSTRACT
Culture shock is an intensely personal universal human experience that may emerge in any cross cultural social encounter. Therefore, it may be deduced that culture shock is an experience that may occur in all spheres of life in which individuals are confronted by world views and life styles that differ from their own whether in terms of health, education or occupation amongst others. It is a situation that calls for adaptation or adjustment on the part of the individual. This article explores the relationship between culture shock and culture adaptation as an aspect of learning which has been developed by Thelma Barer-Stein. Stress is laid on the role of the individual, as health educator, and the choices must make if he/she is to gain an understanding of the community in which he/she serves and to attribute new meanings to the situation by which he/she is confronted.

INTRODUCTION
Every social situation is a coming together, not only of self-concept, self-identity and social roles, but also of shared realities: that which constitutes the intersubjective structure of consciousness.

What is taken for granted by the native is problematic for the stranger. In a familiar world, people live through the day by responding to daily routine without question or reflection. To strangers, however, every situation is new and is therefore experienced as a crisis” (Parillo, in: Gudykunst and Kim, 1984:221).

When people meet who have been socialised within groups with different objectives, but more particularly, subjective cultural characteristics, a cross cultural interaction occurs. The unintentional conflict that emerges as a result of a misunderstanding or the misreading of the cultural cues within the cross cultural encounter is usually experienced as some form of ‘culture shock’ by both educators and learners alike (Arthur, 1995: 310-311).

CULTURE SHOCK
The concept of ‘culture shock’, as introduced by Oberg (1958), traditionally has been used in regards to people belonging to a particular cultural or sub-cultural grouping who settle, either temporarily or permanently, amongst those whose cultural affiliations are different from their own. However, in a world characterised by increasing globalism, the notion has been transferred into the arena of business management in international corporate conglomerations. Barer-Stein (1987 (a); 1987 (b); 1988), has translated the theme into a theory of culture adaptation as an aspect of learning. This is the sense in which the reality of culture shock plays an important role in the success attained by health educators when working with groups whose cultural frame of reference is different from their own.

‘Culture shock’ is the term used to describe anxiety stemming from a person losing his sense of ‘how’ and ‘when’ to do the right thing and the ensuing process of adjustment. Initially, the situation involves a non-specific state of uncertainty in which an individual does not know what others expect of him or what he can expect of others in respect of behavioural, psychological, emotional, or
is good; an emotional disorientation ranging 
quoted indicators of culture shock include an 
cognitive responses. The most frequently 
The education in the cross cultural encounter, the 
the intercultural experience. The second 
stages. The first stage of initial contact has 
frustrated by their inability to interpret the 
by the intercultural experience. The second 
stages. The first stage of initial contact has 
the second and third stages as described and aptly labels them 
the ‘hostility phase’ during which fear, dislike 
be commonly experienced emotions (Rothenburger, 1990: 1352). 
this stage is very volatile as ‘reintegration of new 
takes place. Things are getting better, but not fast enough. People begin 
understand the subjective culture of those with 
whom they work and the way in which things 
are perceived and accomplished in the new 
environment. The fourth stage of ‘developing 
new identity’ begins when both differences 
and similarities are acknowledged. The 
individual becomes more self-assured as he 
learns to function in accordance with the new 
conditions, accepts the strengths and 
weakness of his old and the new system, 
adopts some of the local values and becomes 
integrated within the new social network. 
This is the phase in which acculturation may 
be perceived to have set in. The fifth stage 
ideally leads towards a multi- 
-cultural identity. In essence, a stable state of mind 
is reached ranging from a preference for what 
has gone before, true bicultural adaptation in 
which the present is on a par with the past or 
total conversion to the new environment (Cuscher, 1989:320; Hofstede, 1991:209-210; 

Pedersen (1994: 193) suggests that recent 
research on culture shock demonstrates that 
while the process may be painful, it is not 
necessarily a negative experience for it results 
in new insights and positive human growth. 
Conversely, when intergroup contact fails, the 
end result frequently includes exclusionary 
behaviour such as biased evaluations, 
denigration and disparagement of others, 
blaming the victim or displacement of the 
blame for one’s actions, self-righteous 
comparisons justifying retaliations, 
dehumanisation of the individual, double 
standards and psychological distancing 
amongst others. Any one of these responses on 
the part of the health educator, singly or in 
combination, negatively influences the 
outcome of health education programmes in 
cross cultural encounters.

Barer-Stein (1988:89), having developed a 
theory that incorporates notions of culture 
adaptation and culture shock as aspects of a 
process of learning, hypothesized that it may 
be less important for educators to be familiar 
with the countless details of custom, values, 
language, behaviour et cetera, than is it for 
them to understand their own learning as a 
process.

EXPERIENCING THE 
UNFAMILIAR: CULTURE 
ADAPTATION AS AN ASPECT OF 
THE PROCESS OF LEARNING.

If enculturation is the outcome of the 
acquisition of new knowledge and skills, then 
it may be posited that enculturation is the first 
step towards acculturation or the ongoing 
phenomenon of change that occurs when people 
with different world views come into 
continuous first hand contact with one 
another. The act of learning itself implies 
change (Arthur 1995: 321-322) and the 
education encounter provides an environment 
where educators and learners should 
assimilate some of the views, perceptions and 
ethos of one another during the course of 

Existing circumstances and cultural content 
determine what is accepted and thus learned 
or what is rejected and, therefore, not learned. 
If one accepts the truism that people do not 
learn what is already known, but learn in 
youring degrees what is not known, it may be 
concluded that learning is an ongoing "...
sequential process of experiencing that which 
is different or unfamiliar" (Barer-Stein, 
1987(a):89). The question may now be posed 
as to whether a relationship exists between 
learning, adaptation to culture difference and 
culture shock. If culture represents the many 
ways in which people group together, 
constitute, understand and live their daily lives 
while at the same time transmitting their way 
of life to others, then cultural adaptation in 
cross cultural encounters must involve 
learning in the form of some sequence of 
modification or adjustment to a different 
mode of daily living. A connection between 
learning and attainment of cultural 
understanding is thereby established. Culture 
shock, in these terms, may be viewed "...as 
a synonym for coming face to face with the 
unfamiliar" (Barer-Stein, 1988:88): an experience which may occur in any sphere of 
life whether in terms of health, occupation or 
education amongst others.

In developing a model of the process of 
experiencing the unfamiliar, Barer-Stein 
(1987(a): 91-92, 94) draws on her 
conceptualisation of 'Surface' and 'Submerged Knowledge'. The former 
represents knowledge of which a person is 
fully aware and the latter, the more obscure 
levels of knowledge that require effort to 
recapture. Intrinsic to the approach is an 
acknowledgment that human consciousness, 
however fleeting, is an awareness of being 
faced with that which is unfamiliar or 
different. The experience is accompanied by 
deliberate effort by the individual to exhume, 
analyse and interpret or reflect on the event. It 
is an attempt to force aside a natural reluctance 
to think about that which is unfamiliar and 
potentially disturbing in order to realise new 
posibilities and new meanings. As a result 
of the new understandings derived from in-depth 
thought or reflection, people are able to 
reconstruct their current knowledge and 
activities so that their new insights can be 
acted upon. In other words, learning takes 
place in the form of accommodating to the 
unfamiliar.

The phenomenologically based model 
comprises five phases, each of which is 
associated with essential themes or 
characteristic behaviours that permeate the 
total process with varying degrees of 
maximum. Each level, reflective pause 
occurs during which a decision is made 
whether to move forward towards further 
understanding or not. At least three sets of 
interpretive cognitive activities are involved, 
namely:

• a collecting of information;
• a questioning of that which is collected and 
• a comparison with previous knowledge;

The themes are experienced throughout, either 
cyclical or on a sequentially regressive or 
progressive basis. Each phase is entered into 
voluntarily as a matter of individual choice. 
The possibility of remaining in a phase or 
phase is linked to the individual’s personal 
experience of cultural difference and his/her 
response to such differences.

The initial phase of the model, labelled Being 
Aware, denotes access to the unfamiliar. The 
individual must "... be aware of something in 
order to distinguish it from anything else" 
(Barer-Stein, 1987(a):95; 1987(b):30). The 
three themes or behaviours within this phase 
represent

• an awareness of the interest itself;
• curiosity in the sense of a desire or need to 
know and
• seduction in the form of an inducement or 
incentive to do something about the situation.
The second phase of Observing suggests an attentiveness to that which is observed. Brevity and superficiality are characteristics of the reflective pause at this stage. There is no real focus, commitment or responsibility to act. The individual is merely a spectator to that of which he has become aware and now observes. Should attentiveness intensify and focus on a specific interest, the theme of spectator progresses to that of sightseer (Barer-Stein, 1997(a):95-96; 102; 1987(b):30-31; 1988:81).

The third phase of Acting, more appropriately called Acting in the Scene, depicts a movement closer to the object of interest by the individual, from audience to participant. The associated theme or behaviour labelled witness-appraiser indicates an intensification of reflective pause as the individual repeatedly delves deeper into his accumulated and increasing knowledge of the event and of self. Activity melts into that of cultural-missionary or behaviour characterised by a perception that the world is divided into those who have certain collections of knowledge and those who do not. The perception embodies a conviction that one’s own culture is correct and is accompanied by a concomitant zeal to do something for those perceived as less fortunate in the form of sharing (perhaps imposing) the benefits of one’s own culture on them. The dichotomy between cultures becomes so complete that individual differentiations blur as other people are viewed as homogenous groupings. Stereotyping occurs. The “... judgemental sweeping up of other individuals... into one indistinguishable mass...” (Barer-Stein, 1987(a):97; 1987(b):32) has been labelled cluster-judgement and depicts the ‘we-they’ dichotomy. Since neither group in this dichotomy is able to comprehend the complexity or reality of each other’s culture, cluster-judgement becomes apparent on both sides. Living the life of is the last essential behavioural theme of this phase and represents an ultimate expression of professed familiarity with an unfamiliar situation. It involves an over-identification of the case with which a person is able to fit into the life-style of another group (Barer-Stein, 1987(a):96-98; 1987(b):31-33; 1988:81).

Confronting, or the fourth phase, is commonly taken to imply impending conflict, but carries the implication of coming face to face with something not previously recognised. The complexity of the life-style of the other group now becomes increasingly apparent. A shift in behaviour occurs as the unfamiliar within the familiar is disclosed, either as an aspect of daily life or from within the self. Security is undermined when the familiar ceases to yield to meaning when reflective pause is applied. The perception that familiar practices no longer work increases and solidifies. As always, the individual has a choice. He may choose to be passive and ignore the confrontation and allow it to pass in a way that denies the capacity for transcending what is learned, thereby inhibiting forward movement. Alternatively, he may choose to engage in conflict utilising the various mechanisms for conflict resolution to disprove the differing reality or he may withdraw into himself or his past familiar world to escape the source of his anxiety. The possibility of a continued Awareness of Interest always exists, in which case the individual transcends or rises above his immediate situation and expands his present reality through the discovery of new meanings and greater understanding (Barer-Stein, 1987(a):98-99; 1987(b):35-38; 1988:82-83).

The final phase is that of Involvement. It represents the reality of experiencing the unfamiliar in such a way that the object or subject that was different now finds an integral place of importance as part of the personality of the individual together with all the other personally relevant meanings that make up his/her daily life. Inherent in the final phase of Involvement is a movement towards a phenomenon that occurs when a particular interest becomes so deeply entrenched within the personality that it becomes internalised and an inextricable part of the self. It becomes one with the daily life of the individual.

Barer-Stein’s approach to culture adaptation places emphasis on the individual’s experience and his response to that experience as opposed to culture per se or group relationships. It is an approach that is of direct relevance to the work of health educators when working with groups of people whose world view is different from their own whether in respect of health related matters, social roles and role expectations, or patterns of communication.

IMPLICATIONS FOR HEALTH EDUCATORS

Education or cultural adaptation cannot be said to have taken place as long as learning (as an aspect of understanding that can be acted upon meaningfully) dwells in any place outside of the self. Learning only becomes unique and personal part of the self when it is used in some way through an act of involvement. In other words, the onus is on health educators to think deeply or reflect on that which is different or unfamiliar about the culture of the community in which they work. Health educators need to become consciously aware of the fact that they may be experiencing culture shock in varying degrees in their encounters with others whether in terms of ethnicity, social class, gender or rural-urban distribution. Culture shock may manifest in a variety of responses ranging from surprise that people cannot see the benefits of what is being offered to outrage that communities reject what is perceived as being the only logical effective course of action.

Barer-Stein’s approach offers a means for health educators to gain a conscious understanding of the unfamiliar through acts of reflection in order to guide communities to learn more effectively about health related matters. In this sense, the cultural adaptations required are related to the occupational role of the health educator and not necessarily with a view to becoming integrated within the community itself.

The first two phases in Barer-Stein’s model are familiar to all health educators - at least in respect of the objective culture. All are Aware of unfamiliar beliefs and practices and are compelled to be interested in these features as they impact directly on their field of work. Curiosity is generally present in so far as prior training has stressed the need to identify differences with a view to doing something about them. The incentive, goal or seduction element has been built into objective planning sessions. Observing is another built-in factor of health education training. For many, the commitment remains at the level of spectator or sightseer in which differences in objective behaviour are noted with a view to changing those perceived to be detrimental to health. At this stage, health educators often are stimulated by the challenges posed by health education in the cross cultural encounter but all too frequently, the subjective rationale underlying the beliefs and practices of the community are ignored. Frequently, there is no awareness of the subjective aspects of culture nor of the fact that many variables which directly affect the outcome of educational programmes, are not subject to external observation. Failure to reflect deeply on difference as observed and to concentrate purely on objective observations results in previously mentioned behaviours such as biased evaluations, stereotyping, projection of failure onto clients and the community and mistrust as well as non-realisation of the goals of health education and health promotion.

It is impossible for health educators not to Act in the Scene for they are active participants in all educational events. Questions arise concerning the nature of the participation.

• Is the approach based on direct advice stemming from professional health related knowledge and objective observed difference? If the answer is in the affirmative then health educators cannot be said to have progressed from the second phase of Observing and the end result of their efforts is likely to be almost inevitable failure.

• If a decision is made to move forward in an attempt to understand the community through acts of analysis and interpretation, what are the potential outcomes of such reflection? So often, the behaviour of the educator, represented by the label witness-appraiser, gives rise to the activities of the cultural missionary. Such an approach can, and is, in a tendency towards imposing personal, professional and cultural practices on others. This action results in cluster-judgement and a reinforcement of the “we-they” dichotomy in which dislike and distrust become
manifest. Further progress is unlikely to take place without client-community participation in order to establish the subjective experience of health related matters by both individuals and groups within the community. In this connection, individuals should not be treated in isolation from their reference groups (Dovey & Mjngwana, 1985:82) for it is a truism to state that psychological, social and physical problems are usually 'group' and seldom 'individual' problems. Shared subjective experience is essential in providing health educators with the necessary baseline information on which to ponder and reflect.

- The question 'where to now?' becomes relevant. At this stage, health educators may reach the stage of an oversimplification of their understanding of the life-style and world view of their clientele as outlined in Barer-Stein's essential theme of living the life.

In order to promote movement towards further understanding, the notion of community participation needs to be extended to that of participative learning where learners are called upon to contribute their wide range of knowledge and experience to the educative event. It is a process in which the reservoir of knowledge and experience of clients and educators are integrated. It is also a process during which it is recognised that the health needs as perceived by professionals may not coincide with those of the community itself. Needs are not present unproblematically in people's lives, but proceed from their interests and goals based on value judgements (Alexander, 1987:137) which evolve from differing socio-economic, cultural and political contexts. It also may be assumed that any group coming together for educational purposes may not coincide with those of the community itself.

Involvement entails an acknowledgement that both similarities and differences co-exist within and across cultures. The unfamiliar is experienced in such a way that health educators need to move beyond a pre-occupation with self to understand and confront the issue of how their personal prejudices and prior understandings influence the outcome of any cross cultural encounter. Focus is brought to bear on building mutual understanding rather than concentrating on specific areas of overt cultural difference (Broome, 1991:245-246). In the context of health education, the educator acquires a readiness to suspend taken-for-granted norms in favour of a critical stance towards the everyday experiences of others (Collins, 1984:180-181) as integral part of the self.

As the health educator begins to place emphasis on the experience of cultural difference as opposed to cultural difference per se, the potential for learning that which is unfamiliar is increased. Deeper insights into the reality of the cross cultural health education encounter may be characterised by the emergence of unique norms and values which may not have existed previously. "A shift into a different behaviour than was previously experienced." (Barer-Stein, 1988:81) or entrenchment takes place.

Acculturation in health education practice may be perceived to have set in once the health educator moves away from conventional educational methods which entrench the educator as expert, to those methods founded on placing education within the context in which the cross cultural encounter takes place. By so doing, educators and learners are able to explore the conditions that constitute the structure of their respective life-worlds and come to some understanding of the variables affecting these worlds in order to plan for and take purposeful action to bring about desired change in health related matters with the community. In exploring options for change, the cognitive map of health educators can be extended and limitations in the vision of learners can be reversed (Mitchell, 1991:19) in order to realise the aims of health education and health promotion.

CONCLUSION

"Health education is an essentially practical activity rooted within educational practice" (French, 1990:9) in which interpersonal and intergroup relationships are an integral part: From the preceding discourse, it may be accepted that in order to develop cross cultural understanding, educators must be motivated to put the necessary effort into working through differences, demonstrate sufficient commitment to the encounter to overcome potential areas of breakdown, be willing and able to explore and negotiate alternative meanings for ideas and situations and be willing to participate in mutual creative exploration in a search for the development of a 'third culture' (Broome, 1991:246-247). The concept of third culture entails a focus centred on the co-operative creation of a shared reality pertaining to health related matters between health educators and clients as opposed to attempts to understand individuals and communities as separate objective cultural entities (Broome, 1991:247).

The initiative for the building of shared meaning between themselves and the community they serve lies in the hands of health educators. Barer-Stein's (1988) approach towards "Experiencing the Unfamiliar: Culture Adaptation and Culture Shock As Aspects of a Process of Learning" provides the means whereby health educators, by an act of intent, can move beyond a focus on specific areas of overt cultural differences and preoccupation with self to an understanding and confrontation as to how their personal prejudices and prior understandings influence the outcome of health education in cross cultural encounters.

REFERENCES


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