

BELIEFS, VALUES AND INTERCULTURAL COMMUNICATION

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INTRODUCTION

This chapter explores intercultural communication in the health and social care setting. It is written from a psychological perspective and explores some of the variables that are central to the topic of intercultural communication. Little of the current health and social care literature in Britain has addressed the issue of intercultural communication. This chapter argues that understanding minority communication styles and patterns is indispensable for health care workers working with ethnic minority groups. Euro-American cultural values have dominated the social sciences and have been accepted as universal. It attempts to articulate from a cross-cultural perspective, a precise framework in which to view and define the diverse factors at work during intercultural communication. It focuses on the concepts of belief and value and the impact they have on the communicator's behaviour in intercultural communication.

BELIEFS

According to Rokeach (1973: 2), 'Beliefs are inferences made by an observer about underlying states of expectancy'. A belief is any simple proposition, conscious or unconscious, inferred from what a person says or does, capable of being preceded by the phrase 'I believe that' (Rokeach

1973: 113). The content of a belief cannot be directly observed by others but must be inferred by an observer on the basis of the overt behaviour of the believer. What the believer says or does becomes the clue to his or her belief system. A white man who publicly states that he believes black people are equal to him but who resists black people moving into his neighbourhood demonstrates that expressed beliefs are very poor predictors of behaviour (Fishbein and Ajzen 1975).

Beliefs among black groups and the white majority can differ. For instance, a black person and a white person may share the same value of equality. The white person who has never been refused employment or promotion may believe that equality of opportunity exists – after all he/she never had any trouble. However, the black person who has always been relegated to menial tasks with no possibility for advancement perceives the situation differently. He or she believes that he or she has been discriminated against, and that equality of opportunity in employment does not exist.

BELIEFS AND INTERETHNIC COMMUNICATION

Conflict arising from differences in core beliefs among communicators can result in the disruption of interethnic communication. Core beliefs are based on an individual's direct personal experience with reality. They are held firmly and are resistant to change. White practitioners and black clients experience different realities. Such a divergence in experience will consequently result in a different set of core beliefs. Understanding this variation in core beliefs between white and black people points to the enormous distance between interethnic communicators and the problems they must overcome in order to engage in effective interaction.

Given the different realities of majority and minority people living in Britain, conflicts in beliefs serve as a persistent obstacle to interethnic communication.

In interethnic communication, there are no rights or wrongs as far as beliefs are concerned. White social and health care workers must be able to recognise and to deal with their black clients' beliefs if they wish to obtain satisfactory and successful communication.

ATTITUDES

Attitudes are generally conceptualised as having three components: cognitive, affective and conative (Baron and Byrne 2002). The cognitive component involves our beliefs about the attitude object. The affective

component involves our emotional or evaluative reaction to the attitude object. Finally, the conative component of an attitude involves our behavioural intentions toward the attitude object – for example, an intention to avoid black people.

One of the most disruptive attitudes that can emerge in interracial/ethnic communication is racial prejudice. Allport (1979: 7) defined prejudice as ‘a judgement based on previous decisions and experiences’. While prejudice can be positive or negative, there is a tendency for most of us to think of it as negative. Allport (1979: 9) defined negative ethnic prejudice as ‘an antipathy based on a faulty and inflexible generalisation. It may be felt or expressed. It may be directed toward a group as a whole, or toward an individual because he [or she] is a member of that group’.

Prejudice differs from its behavioural counterpart, discrimination. Prejudice ‘includes internal beliefs and attitudes that are not necessarily expressed or acted upon’ (Ponterotto and Pedersen 1993: 11). An individual who discriminates ‘takes active steps to exclude or deny members of another group entrance or participation in a desired activity’ (Ponterotto and Pedersen 1993: 34). Discrimination may exist in the absence of prejudice due to social pressures to conform or as a consequence of routine institutional practices.

VALUES

Values are influential in dictating the behaviour of a communicator in interethnic settings. Rokeach (1979: 2) defines a value ‘as a type of belief that is centrally located within one’s total belief system’. Values tell us of how we should behave. Values may be explicit (stated overtly in a value judgement) or implicit (inferred from nonverbal behaviour), and they may be individually held or seen as part of a cultural pattern or system. In addition to our unique set of personal values, individuals hold cultural values. Culture-bound values are especially relevant for intercultural communication. These include power-distance, uncertainty avoidance, individualism versus collectivism, and masculinity (Hofstede 1983); low and high context communication, immediacy and expressiveness (Hall 1966); emotional and behavioural expressiveness, and self disclosure.

There are several different conceptualisations of how cultures differ. Hofstede’s work represents the best available attempt to measure empirically the nature and strength of value differences among cultures. He published the results of his study of over 100 000 employees of a large multinational in 40 countries (Hofstede 1983) and identified four dimensions that he labelled power-distance, uncertainty avoidance, individualism and masculinity.

POWER-DISTANCE

Each culture, and all people within cultures, develop ways of interacting with different people according to the status differential that exists between the individual and the person with whom he or she is interacting. Power-distance (PD) refers to the degree to which different cultures encourage or maintain power and status differences between interactants. Cultures high on PD develop rules, mechanisms and rituals that serve to maintain and strengthen the status relationships among their members. Cultures low on PD, however, minimise those rules and customs, eliminating, if not ignoring, the status differences that exist between people.

UNCERTAINTY AVOIDANCE

Uncertainty avoidance (UA) is a dimension observed in Hofstede's (1983) study that described the degree to which different cultures develop ways to deal with the anxiety and stress of uncertainty. It refers to 'how well people in a particular culture tolerate ambiguity and uncertainty' (Hofstede 1983: 65). Sex differences in 'uncertainty avoidance are negligible ... [and] the most important correlations are with national anxiety level' (Hofstede 1983: 110).

Differences in the level of uncertainty avoidance can result in unexpected problems in intercultural communication. For instance, when white British social workers communicate with a client from Pakistan, they are likely to be perceived as too non-confirming and unconventional by the client, and the social workers may view their client as rigid and overly controlled. Social and health workers need to have an understanding of the consequences of uncertainty avoidance for intercultural communication.

INDIVIDUALISM VERSUS COLLECTIVISM

Individualism and collectivism have been two of the most extensively studied concepts in the field of intercultural communication (e.g. Hofstede 1983; Triandis 1986) and is the major dimension of cultural variability used to explain intercultural differences in behaviour. Individualism refers to 'the subordination of the goals of the collectivities to individual goals, and a sense of independence and lack of concern for others', and collectivism refers to 'the subordination of individual goals to the goals of a collective and a sense of harmony, interdependence, and concern for others' (Hui and Triandis 1986: 244–245).

While cultures tend to be predominantly either individualistic or collectivistic, both exist in all cultures. Individualism has been central to the life of Western industrialised societies such as the US and Britain (Hofstede 1983). Collectivism is particularly high among Asian and African societies. However, diversity within each country is very possible. In the US, for instance, Hispanics and Asians tend to be more collectivist than other ethnic groups (Triandis 1990), and in Britain, Asians and African Caribbeans tend to be more collectivistic than white people.

To summarise, the individualism–collectivism dimension allows for similarities and differences in communication to be identified and explained across cultures.

MASCULINITY

The masculinity dimension refers to the degree to which cultures foster or maintain differences between the sexes in work-related values. Cultures high on masculinity such as Japan, Austria and Italy, were found to be associated with the greatest degree of sex differences in work-related values. Cultures low on masculinity – such as Denmark, Netherlands, Norway and Sweden – had the fewest differences between the sexes.

LOW AND HIGH CONTEXT COMMUNICATION

A high context communication or message is one in which ‘most of the information is either in the physical context or internalised in the person, while very little is in the coded, explicit, transmitted part of the message’ (Hall 1976: 79). High context cultures pay great attention to the surrounding circumstances or context of an event; thus, a high context communication relies heavily on nonverbals and the group identification/understanding shared by those communicating. It therefore follows that in interethnic communication the elements of phrasing, tone, gestures, posture, social status, history and social setting are all crucial to the meaning of the message.

As with individualism–collectivism, low and high context communication exists in all cultures, but one tends to predominate. Understanding that a client is from a high or low context culture, and the form of communication that predominates in these cultures, will make the black client’s behaviour less confusing and more interpretable to the practitioner.

IMMEDIACY AND EXPRESSIVENESS

The ‘immediacy dimension is anchored on one extreme by actions that simultaneously communicate closeness, approach, accessibility, and at the other extreme by behaviours expressing avoidance and distance’ (Hecht *et al.* 1989: 167). Immediacy is the degree of perceived physical or psychological closeness between people (Richmond and McCroskey 1988). Immediacy behaviours communicate warmth, closeness and availability for communication. Examples of these behaviours are smiling, touching, eye contact, close personal distance and vocal animation. Cultures that reflect immediacy behaviours or expressiveness are often called ‘high contact cultures’ (Hall 1966).

EMOTIONAL AND BEHAVIOURAL EXPRESSIVENESS

Emotional expressiveness refers to the communication of feelings and thoughts. It ‘can refer to both one’s own and one’s partner’s expression, with lack of expressiveness on either one’s part seen as dissatisfying’ (Hecht *et al.* 1989: 392).

Hecht *et al.* (1989) report that African Americans perceive emotional expressiveness as important to their communication satisfaction with whites (European Americans). Other independent variables – related to communication satisfaction – identified by black people include: acceptance, authenticity, negative stereotyping, understanding, goal attainment and powerlessness (see Hecht *et al.* 1989 for a detailed review). Africans and African Caribbeans tend to be emotionally expressive, while whites have a more emotionally self-restrained style and often attempt to understate, avoid, ignore, or defuse intense or unpleasant situations. One of the dominant stereotypes of African Caribbeans in British society is that of the hostile, angry, prone-to-violence black male. It is not unusual for white practitioners to describe their black clients as being ‘hostile and angry’ (for example, see Fernando 2002).

SELF-DISCLOSURE

Self-disclosure refers to the client’s willingness to tell the practitioner what she/he feels, believes or thinks. Interethnic comparisons of self-disclosure patterns show that European Americans are more disclosive than African Americans (Diamond and Hellcamp 1969) and Asians (Segal 1991).

Indeed, Segal (1991: 239) describes Indians as being ‘reserved and reluctant to discuss their problems outside the family’. Most forms of counselling tend to value one’s ability to self-disclose and to talk about the most intimate aspects of one’s life. Indeed, self-disclosure has often been discussed as a primary characteristic of the healthy personality. The converse of this is that people who do not self-disclose readily in counselling are seen as possessing negative traits such as being guarded, mistrustful and/or paranoid. Intimate revelations of personal or social problems may not be acceptable to many Asians, since such difficulties reflect not only on the individual, but also on the whole family.

Social and health care workers unfamiliar with these cultural ramifications may perceive their clients in a very negative light. They may erroneously conclude that the client is repressed, inhibited, shy or passive. On the other hand, Asian clients may perceive the ‘direct and confrontative techniques [of white practitioners] in communication as “lacking in respect for the client”, and a reflection of insensitivity’ (Sue and Sue 2002: 51).

Black people may also be reluctant to disclose to white practitioners because of hardships they have experienced via racism (Vontress 1981). For black people, ‘race is a significant part of history and personal identity’ (Vontress 1981: 16). Thus, the reality of racism in British society needs to be acknowledged in any counselling or social work relationship involving a black client (Phung 1995).

IMPLICATIONS FOR SOCIAL AND HEALTH CARE SERVICES

Each of Hofstede’s four dimensions provides insights into the influence of culture on the communication process. As frames of reference, Hofstede’s dimensions provide mechanisms to understand interethnic communication events. For instance, the consequences of the degree of power–distance that a culture prefers are evident in the relationship between the client and social worker. Clients raised in high power–distance cultures are expected to comply with the wishes and requests of their social workers and doctors, and conformity is regarded very favourably. Even the language systems (for example the Korean language) in high power–distance cultures emphasise distinctions based on a social hierarchy. Witte and Morrison (1995: 227) note that ‘in many cultures [for example Asian], authority figures cannot be disagreed with, challenged, or contradicted’. Thus, ‘differences in communication styles between healers and patients, especially in terms of politeness behaviour, may lead to miscommunication and misunderstandings’ (Witte and Morrison 1995: 227).

A white practitioner with a monocultural perspective will view any behaviours, values and lifestyles that differed from the Euro-American

norm as deficient (cultural racism). He or she will, for example, view certain nonverbal behaviours (lack of eye contact) as deviant behaviour. Eye contact during verbal communication is expected in Western culture because it implies attention and respect toward others. Among Asians, however, eye contact is considered a sign of lack of respect and attention, particularly to authority and older people. Cultures differ in their values on individualism versus collectivism; low and high context communication; immediacy and expressiveness; uncertainty avoidance; emotional and behavioural expressiveness; and self-disclosure. People from different cultures have different patterns of communication. Asians, coming from a high context culture, often rely on nonverbal communication, while Euro-Americans rely more on words. Asians' oral messages frequently are more implicit and depend more on context (people and situations), while Euro-Americans' verbal messages are explicit and less concerned with context. Members of Asian cultures are more likely to be offended by direct and explicit messages and prefer indirect and implicit messages (Witte and Morrison 1995). There may be clear rules regarding how older members of the family should be addressed by the younger members. This attitude will influence the doctor–patient or social worker–client relationship, because if the patient or client is not used to challenging authority figures they will conform to everything suggested by the doctor or social worker. Problems with medical regimens may occur unintentionally or intentionally due to these politeness norms.

Many social and health care practitioners are not aware of their own value biases (Sue and Sue 2002). Katz (1985: 616) points out that 'because White culture is the dominant cultural norm in the United States [and Britain], it acts as an invisible veil that limits many people from seeing it as a cultural system'. There is an identifiable 'dominant' value system in Britain that is associated with the majority (white middle class) group, and which pervades most social work courses (Dominelli 1997). Practitioners need to understand the value bases of the power–dominant cultural system that forms the basis of training and practice. White people in Britain are raised to believe that their value system is the most appropriate, 'the best', and that people possessing non-middle class white values should try their best to assimilate and adapt to the majority culture system. This ethnocentric bias serves as a barrier to effective interethnic communication. Social and health care workers who have little understanding of black (Asian and African Caribbean) culture tend to look upon the black client's values and culture as inherently inferior to their own. For example, as noted earlier, black people come from cultures that value group affiliation and collectivism. Practitioners from a Eurocentric perspective – where individualism is valued – may misinterpret the behaviour of these clients as codependency.

Most major theories of social work, counselling and psychotherapy originated in Eurocentric ideology. To use traditional counselling theories

beneficially with black people, counsellors need to evaluate them for cultural bias. Some assumptions identified by Pedersen (1988) reflecting cultural bias in counselling are:

- a common measure of 'normal behaviour';
- emphasis on individualism;
- overemphasis on independence; and
- cultural encapsulation.

Traditionally trained counsellors and social workers are so caught up in their own belief system that they are unaware of their specific values, and they neglect to realise that there are alternative, equally justifiable cultural value systems.

CONCLUSION

Some disparity does exist in beliefs and values between communicators of different racial and cultural backgrounds. There is no simple effective solution to the problem of interethnic belief and value conflict. However, social and health care workers must try in interethnic settings to step outside themselves in order to gain an understanding of the reality of others.

Social and health care workers should be aware both of their own attitudes and behaviour and those communication situations in which they are likely to display negative behaviours. Such an awareness is at least a first step in mitigating problems in black and white verbal and nonverbal communication. Practitioners need to be conscious that racist attitudes, even when expressed in a subtle or unconscious fashion, can disrupt the interethnic communication process.

Social and health care workers need to have an understanding of the taxonomies that can be used to describe cultural variations. These taxonomies include Hall's high and low context cultural patterns and Hofstede's four dimensions – power–distance, uncertainty, avoidance, individualism–collectivism, and masculinity–femininity, along which the dominant patterns of a culture can be ordered. Taken together, these taxonomies provide multiple frames of reference that can be used to understand intercultural communication. Other culture-bound values discussed in this chapter were emotional/behavioural expressiveness and self-disclosure patterns.

The practitioner's values will lead them to communicate in certain ways, because values will determine which ways of communicating are deemed more desirable than others. Conflict in value systems is a major cause of communication breakdown in interethnic settings. As noted

earlier, the problem that arises with the difference in values is that we tend to use our own values as the standard when judging others. We tend to assume that our value system is best, an assumption that causes us to make value judgements of others. White practitioners need to become more aware of their own values and beliefs and should be encouraged to share these in interethnic communication. Practitioners should consciously examine the bases of their values and beliefs and the actual role served by them in their own life as well as in their culture. Workers can then determine whether any of their values and beliefs are serving as deterrents to good interethnic communication.

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