

## The Problems of “Reverse” Culture Shock. An Outline\*

DAN G. HERTZ

### Introduction

It appears to be a nearly impossible task to approach the problems of transcultural psychiatry after these three days of intensive discussion without getting into the danger of becoming repetitions. Therefore I shall try my best to avoid the presentation of ideas and concepts which served for the theoretical basis of this symposium.

The main theme has been duly clarified with a multifaceted approach: namely, what happens to a person or a family when they are suddenly thrust into an alien culture or when they have divided loyalties to two different cultures. In its more extreme form the problem seems to lie in the confrontation of people with new mores and values, often being forced to give up or unlearn all of the automatic daily cues of social behaviour.

In my paper today I would like to examine some specific aspects of the process of migration and acculturation as viewed from psychodynamic perspective of clinical psychiatry.

The methodological problems of this field have been extensively reviewed by FABREGA quoting the pioneer contributions of MURPHY, LEIGHTON, HERSKOVITS and others.

I shall therefore recall only briefly the definition of the two major factors involved. *Migration* is often defined as the (more or less permanent) movement of persons or groups over a significant distance. Of course, the definition becomes more complex when it intends to classify an individual as a migrant e.g. in terms of place of birth, or place of socialization or e.g. age at time of arrival or recency of arrival.

The primary emphasis, however, will be given to migration across national boundaries, so called “international migration”.

The best definition on acculturation was given by REDFIELD *et al.* (1967) as “phenomena which result when groups of individuals having different cultures come into continuous first hand contact with subse-

quent changes in the original culture patterns of either or both groups”.

### New (additional) definitions.

My paper today intends to deal with a different type of migration and with a different type of acculturation.

As the world is unfortunately still divided into developed and developing countries, a justified attempt is continued by both sides to narrow the gap in order to attain a richer technology and a higher standard of living. In order to achieve this, both sides carry out nationwide programs of change, either by sending their specialists to strengthen these programs or sending away their own citizen to obtain higher and additional training to help to develop and implement (eventually improve) projects in their own country, after their return home.

This paper deals with this type of migrant: the “*Returning Resident*”. The question which we have tried to investigate is what happens to the returning resident in his native country after having spent a prolonged period of time away from his home and his own culture.

### Hypothesis

Our working hypothesis was what this type of migration and acculturation might often confront individuals and families with challenges which they are not always prepared to meet. We have considered their re-entry as a crisis situation due to the fact that the psychological impact of this constellation may have been experienced as focused. The ensuing crisis may endanger patterns and coping mechanisms that would become maladaptive and therefore they might eventually create psychological symptoms and bring to some extent of disability. On this theoretical basis an attempt was made to examine whether specific clinical features could be delineated which care connected to the adjustment problems of the returning resident.

\* HERTZ DAN G. 1977. The Problems of “Reverse” Culture Shock. (The “returning resident” syndromes,—psychopathology and its prevention.) In BOROFFKA A. & PFEIFFER W.M. (Hg). *Fragen der transkulturell-vergleichenden Psychiatrie in Europa (Referate und Arbeitspapiere anlässlich des Symposions in Kiel vom 5.4. - 8.4. 1976)*. Münster: Westfälische Wilhelms-Universität, Fach Medizinische Psychologie: 237-243.

Remark of the editor’s office of “*curare*”: The contents of the here cited and during the symposium 1976 shown tables were not longer passed to the printed version of 1977. But the outline itself without the tables is already an important document for remembering, re-thinking and further discourse

### Study population

The study population comprised 76 returning residents who spent at least three years away from their home. In most cases their stay was interrupted only by a short period of home leave during their prolonged absence. The group included returning students, professionals (engineers, physicians, teachers), technicians and employees of different public agencies and private companies. The age range was between 21 to 56, with an average of 38.5—17 were single, 4 divorced, all the others married. In addition to the subjects 42 family members, mainly wives were also interviewed. 30 of the subjects were Israeli born, the others Israeli citizens of European and South American origin. Methodology was based on the technique which has been used by WEINBERG (1961) studying adjustment problems of new immigrants, with major modifications for the examination of family interactions.

Before presenting our findings I would like to recall some of the intrapsychic and interpersonal factors which are usually present in the so-called "Culture Shock".

The intrapsychic factors can be retracted mainly to two basic elements:

- 1) Failure of satisfactory verbal communication (leading to social and emotional isolation)
- 2) Value conflicts—when having been confronted with the new (host) culture.

On the interpersonal level: Cultural misunderstanding and underestimation of the potential of the recipient community play a major role. (Table 1)

### Findings

In comparison to the above factors the examination of the subjects who have been exposed to the "Reverse Culture Shock" reflected a variety of additional intrapsychic factors. (Table 2)

Initially marked ambivalence was expressed toward the change. *Overidentification* was found often with the value of the more affluent host country. Even in those cases where on the conscious level criticism was expressed toward the host, an unconscious identification was found. (In psychoanalytic terms it corresponds with the definition of: identification with the aggressor.)

Exaggerated expectations from the return were often based on *overridealisation* of the period antecedent the departure and on denial of possible difficulties after home coming.

On the interpersonal and environmental level similar discrepancies were detected: Intrafamilial ambivalence was a complementary factor to the individual hardship.—Due to the intrapsychic disappointments external strains were much less tolerated than under normal conditions. Changes of the stimuli (which were emphasized in EITINGER'S excellent study in 1960) were often perceived with opposite reaction (namely the sudden disappearance of the hectic metropolitan environment created longing instead of relief). The examination of the subjects reflected four major areas of conflict in the returning resident and his eventual family.

The psychological defenses utilized in each category show a wide and rather distinct division: The intrapsychic conflicts are usually dealt with by withdrawal, projection or frequently displacement.

Marital conflicts are characteristically approached either by *selfcrimination* (turning aggression against one self) or projection and eventually acting out.

The intrafamilial conflicts are again attempted to be solved either by a sudden change of attitude toward increase of control or complete inertia to cope with the difficulty. This tendency is often changed into "acting out" behaviour.

On the social level the ambivalent attitude brings often to either complete avoidance to face realities upon return or mobilization of aggressive tendencies, resulting in a rejection of the home values. (Table 3)

The clinical manifestations associated with the reverse culture shock therefore reflect a great variety of psychopathological conditions, ranging from Mild transient situational stress reaction through manifestations of a wide range of neurotic disturbances and personality trait factors to severe acting out phenomena not only in the resident himself but in his family as well. (Table 4)

The course of reverse culture shock bears several other characteristics of a typical crisis situation. Usually the environmental difficulties are used as the first indicators of a crisis in development. With the relative progress of the decrease in the intensity of the environmental stress, the emotional difficulties might show a sudden rise of the anxiety level. The correlations of the environmental and individual difficulties can be considered as indicators in the prediction of the final outcome of the crisis.

This should be apparently true also in case of family reactions of the returning resident. (Table 5, 6, 7, 8)

During the follow up of the clinical case material, we have tried to isolate the risk factors involved in

the development of the unfavourable psychological reactions connected with the “reverse culture shock”. (Table 9)

*Duration of absence from home* and the *extent of alienation* from one’s own culture are considered as of primary importance in the pathogenesis.

*Age* and *social status* have a definite connection as found in any other crisis situations.—*Adolescence* and *involution* are the major risk group,—*loneliness* (in single, separated and senescent residents) increases the proneness to higher risk. *Previous* (even minor) *individual and family pathology* has to be definitely and taken into consideration as a probable indicator for future difficulties.—It has been only retrospectively found that *motivational factors* have to be carefully examined. “*Moving away*” from certain social constellations instead of “*moving toward*” well defined ego-syntonic goals is an important factor in predicting the probability of potential crisis.

*Lack of positive home and family ties* are complementary factors in the pathogenesis of social isolation and in the increase of adjustment difficulties of the returning resident. It remains an open question how the above factors (if at all) can be properly evaluated and utilized in the prevention of unwanted reactions.

With the emphasis of our awareness of the danger of oversimplification of a very complex area of theorem, I shall try to summarize the major diagnostic findings involved in the clinical picture. The disturbances are most pronounced in the area of cognition, affect and the value system. Manifestations therefore are expressing the breakdown of those systems in the form of *disorientation, detachment and disillusion*. (Table 10)

Corrective measures and therapeutical efforts therefore should apply those technics of crisis intervention which can efficiently influence the above maladaptive features. The proper strategy of *information dissemination*, combined with *desensitisation* with regard to the period of transition and organized *emotional support*—often on administrative level—are considered the major therapeutic tools—in the prevention of the severe manifestations. (Table 11)

*To summarize:* An attempt was made to describe a well-known but until now relatively neglected area of emotional difficulties connected with maladjustment of “returning residents”.

Psychodynamics of symptom formation have been described, basic principles of preventive measures have been outlined.

We would like to emphasize our awareness of the limitations of this pilot study. Therefore it should be considered only as a modest attempt on our part to try to shed additional light to the complexity of preventive and curative mental health activities related to the problems of migration. We hope that our contribution may add new parameters to the very much needed further research and care of the mental health of migrants.

I would like to conclude by quoting from a paper written with my late colleague, the Israeli psychiatrist of Dutch origin. Dr. Weinberg the author of a book on immigrants to Israel, named *Migration and Belonging*: “We are all migrating from the moment of birth until the hour of death. Human life is on chain of multiple migrations, till the day of one’s last migration – to death. The more man enjoys the blessing of being helped in his life-long migration, the less he will be in danger of suffering from inner insecurity and concomitantly the less he will suffer from basic anxiety.”

#### Notice to the author:

G. DAN HERTZ was a Professor of Psychiatry at Hebrew University—Hadassah Medical School Director, Psychiatry Clinic Hadassah University Hospital Jerusalem, Israel. His main topics were psychiatry after the holocaust, psychology of migration and survival, and gynecological psychosomatics. See also:

HERTZ G.D. 1988. Identity—lost and found: Patterns of migration and psychological and psychosocial adjustment of migrants. *Acta Psychiatrica Scandinavica*. Vol. 78, Issue s344 Page 159-165, September 1988

In memoriam—Dan G. Hertz, M.D. *General Hospital Psychiatry* Volume 26, 1(2003)1 (obituary by E. Edelstein)

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— 1969. Rehabilitation of Concentration Camp Survivors. *Psychotherapy and Psychosomatics* 17: 42-49.

See more on the subject: Survivors International <http://www.survivorsintl.org/article.php?story=referencebibliography>

REDFIELD 1967. Several Publications, mostly cited from the original article: REDFIELD R., LINTON R. & HERSKOVITS M. J. 1936. Memorandum for the study of acculturation. *American Anthropologist* 38: 149 - 152.

WEINBERG Abraham A. 1961. *Migration and Belonging: A Study of Mental Health and Personal Adjustment in Israel*. The Hague: Martinus Nijhoff Press

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