The Social-Cultural Preparation of Americans for Overseas Service: *An Approach Drawn From Behavioral Science*[1]

Ted Ward

The strategy for preparation of Americans for overseas service projected in this paper has been adapted from a design for the preparation of teachers, originated on contract to the United States Office of Education. It is based upon tactics drawn from the behavioral sciences.

Rationale

The general task of behavioral science inquiry is relating disciplined and organized knowledge to the solving of problems arising out of human needs. To accomplish this task, knowledge is drawn from many disciplines and is related to a specific problem; hypotheses are formed and are then tested in action. The particular task is to identify the appropriate knowledge that relates to preparing persons from one culture to relate adequately to people of another culture.

The behavioral sciences, for two reasons constitute a useful framework and series of sources for a program in cultural preparation:

1. The dominant task of all educational activity is to develop appropriate behavior within various settings. The behavioral sciences provide the systems of knowledge and inquiry most useful and reliable for this task; and
2. A distinctive feature of empirical science as a way of acquiring knowledge is that it is self-corrective.

Systematic reappraisal of both output (organized knowledge) and methods used to produce that output (methodology) needs to be followed by revision according to the findings of the reappraisal. The behavioral sciences suggest the development of a clinical behavior style in trainees in order to enable them to base their conduct practice upon available knowledge, to produce new information through their behavior and to revise their conduct on the basis of the new information as it becomes available through their experience.

Salient Concepts

A few of the concepts which are pertinent to this model of training require specific definition. In some cases similar terms refer to different concepts in various fields; in other cases the precise meaning of a term has been obscured by careless usage. The following definitions apply to the particular and precise meaning the concept carries in this program model.

Simulated Experiences. When precise control of the presentation of problems and feedback is required, *simulated experiences* are often preferred to "real" experiences. In *simulated experiences* the

[1] Ted Ward, in collaboration with Frank Cookingham, Judith Henderson, Robert Houston, Joseph Coughlin.

behavior of the trainee is no less real, but the data upon which he acts and the responses which his activity elicits are more clearly defined than in "real life." The major advantages of simulation in professional training are these:

1. To allow for a more sequentially ordered progression of problems.
2. To assure that certain critical problems will be encountered--whereas they might not appear during unpredictable field experiences.
3. To provide repeated problem confrontation wherein the specificity of feedback can work toward the establishing of the desired behavior in the trainee.
4. To provide the same experiences in common for a group of trainees in order to establish a common base for discussion and evaluation.
5. To allow the design of feedback to the trainee to be based upon probabilities representative of larger samples.

Simulated experiences may be provided within the training establishment or as part of a series of field experiences.

Field Experiences. Those instructional activities which take place in locations other than the training classrooms and laboratories are called *field experiences*. A *field experience* may differ very little from the typical activity of a classroom, but in that it is off-base it is arbitrarily classified as *field experience*. For example: a national leader from the host country comes to the base to participate in orientation of service men--his is not a field experience; a training group goes to a village or city to visit with national leaders or local officials and carry on a discussion with them--this is a field experience.

Clinical experiences. The three distinct elements which characterize every *clinical experience* are,

1. The element of client relatedness—in which there is actual or simulated, direct or indirect experience with nationals of the host country.
2. The element of *manipulation of instructional variables*—in which the trainee is responsible for one or more of the preparations or operations of the encounter.
3. The element of using *feedback* (learning from doing)--in which the trainee practices and evaluates in such a way as to improve the effectiveness of his dealings with people.

Every training experience containing these three elements is a *clinical experience*, regardless of whether the experience occurs in basic training before going overseas, or in the host nation in which a man is serving.

Clinical. The above three elements interact to give *clinical* a connotation which is greater than the sum of the parts. In the context of training, *clinical* connotes the behavior style (or the gaining of a behavior style) appropriate to providing a professional service to clients in order to produce some intended change, and in such a manner as to learn from the experiences.

Confusion about the meaning of *clinical* can be traced to four sources:

1. The field of medicine lays claim to the word and uses it in several peculiar ways.
2. The field of counseling uses the term in a special and stylistic sense.
3. The discipline of psychology uses the term to make an arbitrary distinction among its fields.
4. The field of teacher training has begun recently to use the term interchangeably with "laboratory" in the phrase "laboratory experiences" and interchangeably with "field" as in "field experiences.

There is no case being made for the replacement of one bit of jargon with another. The concept *clinical* as defined and used here, means, as no other English word can, that aspect of experience (and training) in which the practitioner or trainee encounters the problems presented by his interactions with other people in appropriate settings for intervention and change (development); and in which the orderly processes of dealing with others in these settings generates within him further knowledge and skill. Please note in the foregoing definitions of clinical experiences and clinical the special emphasis upon the fact that clinical experience not only provides service to the client, but provides further learning for the trainee.

Clinical Style in Behavior

The variable nature of problems with which overseas Americans deals requires a routine procedure or schedule of procedures which can be employed systematically to assure the following:

1. They comprehensively describe each new problem.
2. They analyze the description into its important elements and interrelationships to produce a diagnosis.
3. They relate available knowledge to the diagnosis to develop hypothetical solutions or treatments for the problem.
4. They select and adapting a prescription for treatment that has high probability of success.
5. They have the skills needed to administer the treatment.
6. They seek evidence on the consequences of the administered treatment.
7. They use the outcomes of this "practical experience" to augment or revise their own knowledge and skills by continually cycling through phases of proposing and going.

Such a schedule of routine procedures constitutes a particular style of behavior specified here as a *clinical style of behavior*. In other words, the term clinical style of behavior denotes the particular and stylized set of behaviors and mental processes of people who have been specifically trained to utilize their experiences as a continuing source of new learning through which they improve their skills and increase their knowledge.

The paradigm of *clinical behavior style* appropriate for an overseas worker is a cycle of three phases, with each phase consisting of two basic types of activity:

1. The *reflecting* phase
    a) describing
    b) analyzing
2. The *proposing* phase
    a) hypothesizing
    b) prescribing
3. The *doing* phase
    a) treating
    b) seeking evidence on consequences

As people operate within this paradigm, they *reflect* upon a relationship or interaction and produce a diagnosis based upon description and analysis; as they relate available knowledge to the diagnosis they *propose* alternative hypothetical solutions, select the solution most likely to satisfy the needs, and prescribe what must be done to achieve that solution; as they do what is necessary to administer the prescribed treatment, they observe the effects upon others, reflect upon their observations by describing and analyzing the changed situation, relate available knowledge (including the original diagnosis) to the re-diagnosis, augment or revise skills or knowledge as necessary, prescribe additional

treatment as necessary, and so on. Whatever changes in knowledge or skills occur as a result of cycling the outcomes of "practical experience" through the theory-oriented phases of reflecting and proposing become available for better serving others in the future. Thus "learning from experience" moves up to become a *strategy* and characteristic style.

It should be noted here that a *clinical behavior* style is *not* equivalent to a research behavior style. The aim is to produce systematic effective experience, not systematic knowledge, per se. Two critical assumptions underlie the concept of *clinical behavior style* and should be treated as hypotheses in any experimental application of the concept:

1. It is assumed that a person who has been trained to manifest a clinical behavior style will be better able than one not so trained to characterize self-renewal and improvement in his or her human relations.
2. It is assumed that most trainees can be taught to operate within a more or less sophisticated model of clinical behavior.

The behavioral context—a third basic assumption of a more philosophic sort might be added to the two listed above: it is assumed that the emphasis on the trainee's behavioral context will tend to produce in the trainee a bias toward concern for the lives of those with whom he or she is in contact. When viewed as the product of what a person thinks, believes, and values his or her *behavioral context* constitutes a means of linking himself or herself to the global human family. Relevant knowledge can then be defined as information, skills, and procedures that relate to the understanding of humans and to meeting the needs of humanity.