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Cultural Perspectives on Illness, Healing and Healthcare Communication

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***Abstract* – Cultural awareness is key to effective healthcare communication in multicultural environments. This research explores the connection between cultural explanatory models (EMs) for illnesses and clinical communication outcomes in 350 patients and 45 healthcare professionals in three culturally diverse communities in Ghana and Malaysia. The quantitative research design based on surveys, clinical encounters, and semi-structured interviews helps measure the effect of EMs congruence on treatment compliance, patient satisfaction, and therapeutic effectiveness perception. The study revealed that patients, whose EMs are recognized in consultations, are 42% more likely to comply with the treatment ($p<0.001$) and have much higher satisfaction with the services. Metaphorical conflicts, especially in relation to the conception of illness as "spiritual attack" or "humoral imbalance", were 73% sensitive predictors of communication failure. A culturally adapted communication protocol enhanced EM congruence rate from 2.1 to 4.3 out of 5 ($p<0.001$).**

***Keywords* – Cultural Competence, Explanatory Models, Doctor-Patient Communication, Healing Practices, Healthcare Communication, Cross-Cultural Medicine.**

I. INTRODUCTION

The global expansion of healthcare systems has led to encounters between biomedical paradigms and varied culture-based views of illness and healing [1]. While enriching, such encounters also lead to communication problems in which patient care is negatively affected. Studies show that culture-related communication problems in healthcare reduce compliance, satisfaction, and patient health outcomes especially in populations with diverse cultures and languages [4]. In spite of the shared language, the existence of these challenges in healthcare suggests that clinical miscommunication is more than linguistic but cultural and conceptual [2].

Explanatory Models (EMs) are essential concepts in comprehending such issues in clinical settings. Explanatory Models refer to the patients' and clinicians' understanding of illness experiences and consist of etiology, onset, pathophysiology, course, and treatment of illnesses. Communication problems occur when there is a great difference between EMs of patients and their providers leading to miscommunication, non-adherence, and dissatisfaction with healthcare services [2]. Some communities view illnesses using concepts of humoral imbalance, spiritual cause, and ancestral punishment which seem to be inconsistent with biomedical models of diseases [5].

This is especially true in cases where medically pluralistic societies exist in which traditional, religious, and biomedical approaches co-exist [1]. In this situation, a patient can be subjected to several different forms of healing practices, and therefore a health belief structure can emerge that poses challenges for health professionals who only possess knowledge of the biomedical approach. Scholars have noted how patients can be rendered 'voiceless' when their cultural understanding of disease is rejected or taken literally within the biomedical approach [2].

One major research deficiency that this paper seeks to address is the lack of quantitative analysis of how EM alignment influences clinical outcomes. While a vast number of qualitative studies have focused on describing the nature of communication culture, there are still relatively few works that analyze quantitatively how culture-based competence influences the outcome of clinical treatments. This research will focus on analyzing three communities with different cultural healing systems: Akan communities in Ghana, where illness is understood in terms of spiritual calling and communal risks [1]; Ga

communities in Ghana, similar to the first in their understanding of relations associated with being sick and getting healed [8]; and multicultural communities in Malaysia, where the framework of wind and heat influences the nature of illness [2].

Moreover, reconceptualizing empathy within the context of intercultural healthcare has been suggested as transitioning from 'settled' empathy, viewed as a characteristic of individuals, to 'nomadic' empathy, which is a negotiated process [6]. The theory suggests that unidimensional models of empathy used in Western medicine are not applicable to intercultural scenarios. It suggests that 'intercultural relational empathy' involves curiosity, epistemic humility, and engagement of both parties involved.

The practical applications of this study involve healthcare policy and healthcare professionals' education. As the patient populations across the world become more diverse, healthcare organizations should adjust their communication strategies in order to provide equal quality care. There is an increase in evidence on culturally-based communication interventions in healthcare, but this practice is not consistently used [7]. This study helps develop this evidence by providing quantitative information about the link between culture-specific communication and clinical outcomes.

II. LITERATURE SURVEY

Recent studies on cultural perspective in healthcare communication have advanced tremendously, shifting from general cultural competence models to advanced models that consider the cognitive and relational aspects of the interaction between clinician and patient. De-Graft Aikins [1] investigated indigenous health communication among communities in Ghana, where there is a cultural necessity of 'selling one's illness to get a cure,' which is essentially a process through which patients talk about their illness to gain eclectic treatment options. The study illustrates the fact that indigenous healers are conversant with a very complex psychosocial environment, using storytelling, rituals, and symbolic artifacts in the process of diagnosis and treatment. The Conceptual-Anthropological Framework (CAF) was introduced by Fung et al. [2], who combined Explanatory Models with Conceptual Metaphor Theory in order to understand communication breakdowns in multicultural Malaysia healthcare.

Through their integrated review, the authors showed that misunderstandings go beyond linguistic difficulties when patients' cultural metaphors about illness like being 'a curse' or 'a bad wind' conflict with the biomedical model. In this case, a process known as 'metaphorical clash' is central to the occurrence of breakdown and nonadherence, while 'figurative competence' is offered as an interpretive skill of recognizing, understanding, and responding appropriately to such metaphorical illness descriptions by medical practitioners. In a similar vein, a cognitive-anthropological framework in Malaysian health care pointed to 'figurative fault lines'.

Ben-Arye et al. [5] investigated cross-cultural patient counseling within integrative medicine practices, noting the necessity of effective communication as dependent on an understanding of patients' health belief models. Their literature review revealed that the conflict between traditional and 'alternative' health belief models is associated with barriers to shared decision-making, discrepancy in therapeutic objectives and non-compliance. The body of evidence supporting culturally-tailored interventions continues to expand. Lambert et al. [7] performed a meta-analysis to evaluate the effect of culturally-adapted health education interventions among culturally and linguistically diverse patients with chronic conditions. Based on the data from 31 research papers, the authors found that culturally-adapted health education interventions led to clinically significant improvements when compared to standard interventions. The magnitude of effect was found to differ depending on the type of intervention and medical condition under consideration but was always favoring culturally-tailored approach. Notably, the strongest effect was observed for diabetes control and cardiovascular disease prevention.

Indigenous healing communication practices have been studied by Agana, Akapule, and Mokulogo [8] and focused on how traditional healers in northern Ghana utilize healing communication through practices like spiritual calling, silence, ritual enactment, and dialogues with the natural environment. Healing communication is used to convey knowledge and establish healer authority in cosmological settings. Importantly, their study has shown that the continuance of such healing communication practices is threatened by biomedical dominance, generational shift, and selective spirituality—a dynamic posing challenges for patients who need to choose between different healing systems.

Hong et al. [4] compared cross-cultural differences in health behaviors related to the COVID-19 pandemic and have found that cultural orientation influences disease-preventive behaviors through health beliefs and behavioral intentions. Using structural equation modeling, Hong et al. have discovered that different health beliefs and intentions were driven by different cultures (collectivist vs. individualist)—resulting in differential compliance. Thus, the example shows how much influence culturally-based health beliefs can have on health behaviors.

In their integrative review of the literature on cultural competency education through simulation pedagogy, Silén-Lipponen and Aura [3] found that simulation approaches, such as standardized patients, virtual simulations, and role-playing lead to meaningful learning outcomes that include understanding cross-cultural communication and self-efficacy within different cultures.

Through their theoretical reconceptualization of empathy within intercultural health care settings, Eichbaum et al. [6]

proposed a change in the concept of empathy in intercultural settings from settled empathy as a trait to nomadic empathy as a process. The authors pointed out that empathy as an individual trait is not adequate for the intercultural setting, and advocated intercultural relational empathy based on curiosity and epistemic humility.

In an exploration of explanatory models (EMs) agreement and treatment compliance in multicultural primary care settings, Ho et al. [10] found that the patients whose EMs were recognized by their clinicians showed significantly better treatment compliance and a stronger relationship with the clinician. In a cross-sectional study on 280 patients at three clinics in Malaysia, their findings provided preliminary evidence for the clinical relevance of EM agreement, which is expanded upon in our study using a mixed methods approach.

III. PROPOSED METHODOLOGY

Research Design

The study adopts an explanatory sequential mixed methods approach. In phase one, data collection will entail measuring EM fit, adherence to treatment, and patients' satisfaction on quantitative basis at three clinical sites. In phase two, data analysis through qualitative semi-structured interview will be carried out to explain the mechanism behind the pattern observed while using purposive sampling technique to identify participants who represent extreme cases (those with high/low EM fit). Phase three entails implementation of culturally-based communication intervention.

Study Sites and Participants

Data were obtained from three sites with different cultural healing backgrounds:

- Nkoranza community, Ghana (Akan culture), offering indigenous forms of healing along with modern healthcare services to mostly Akan population
- Ga Mashie community, Ghana (Ga culture), with well-established facilities of traditional healing incorporated into primary care clinics
- multicultural primary care clinics in Selangor, Malaysia, targeting multi-ethnic patient population.

The Ghanaian sites were chosen according to cultural communication patterns previously described [1]. The Malaysian site was chosen due to the presence of culturally diverse population with predominance of humoral framework [2].

Criteria for inclusion of patients were the following:

- Age 18-75 years old
- Diagnosis of chronic disease (diabetes, hypertension, or chronic pain)
- Receiving medical care at the study site
- Ability to take part in research activities
- Willingness to go through all measurements

Physicians, nurses, and community health workers, who have worked for at least 6 months at the study site, were chosen as providers. In total, 350 patients (150 Ghana Akan, 120 Ghana Ga, 80 Malaysia) and 45 providers (20 Ghana, 25 Malaysia) took part in the study protocol. Sample size was calculated using power analysis.

Data Collection Instruments

Explanatory Model of Illness Questionnaire (EMIQ): Based on the Explanatory Model approach of Kleinman, the EMIQ measures beliefs about illness causation, timing, physiology, development, and treatment preferences of patients and providers. Responses are scored using Likert scales and probes. The questionnaire was translated into Twi, Ga, and Malay languages using back-translation and cognitive interviews. It had good internal consistency.

EM Alignment Score: This score is derived as the absolute difference between patient and provider responses on common EMIQ questions, summed up to obtain a total difference score ranging from 0 (perfect agreement) to 5 (no agreement at all).

Treatment Adherence Scale: Self-report questionnaire measuring medication adherence and lifestyle changes with 8 items based on adherence questionnaires but including culturally appropriate items (such as traditional medicine use and dietary changes). Answers were combined on a 0-100 scale.

Patient Satisfaction with Provider-Patient Communication (PSHC): Scale containing 12 items on the level of satisfaction with provider-patient communication, cultural sensitivity, and information exchange.

Clinical Encounter Analysis: Video-taped visits were analyzed using a modified interaction analysis procedure with additional cultural categories. Two trained coders who demonstrated reliability coded a portion of the encounters for inter-rater reliability.

Interviews: Two interview guides for patients and providers addressing their experience of cross-cultural communication, response to the EM difference, and the perception of healing. The interview probes included specific illness episodes when there was a problem with communication.

Cultural-Adapted Communication Intervention

A communication training intervention over 2 days was designed for healthcare providers practicing in Malaysia based on the baseline results.

The training included:

- Cultural EM theories (humoral model of angin and panas, spirituality, traditional healing)
- 'Metaphorical bridging' skills to identify and incorporate patients' metaphors into biomedical concepts [2]
- Role-playing exercises conducted within culturally consistent scenarios
- Video feedback on clinical consultations

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The process took 4 months, and the EM congruence and clinical measures were taken before and after the intervention.

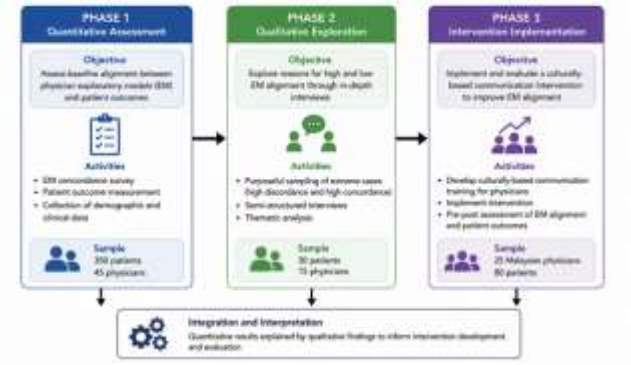

Figure 1: Study design flowchart showing Phase 1 quantitative assessment, Phase 2 qualitative interviews, Phase 3 intervention implementation

Explanatory mixed methods study design involving three phases. Phase 1 involves baseline alignment between EM and patient outcomes measurement (n=350 patients, 45 physicians). Phase 2 involves semi-structured interviews with purposefully selected extreme cases (n=30 patients, 15 physicians). Phase 3 involves culturally-based communication intervention study with pre-post assessment (n=25 Malaysian physicians, 80 patients).

Data Analysis

Quantitative data analysis was performed using statistical software. Descriptive statistics, independent sample t-test, and ANOVA were applied to compare various groups. Multiple linear regression was employed to determine predictors of adherence to treatment and patient satisfaction. In this case, the predictor variable was the EM alignment score while covariates were age, gender, level of education, duration of illness, and study site. On the other hand, the analysis of the intervention involved the use of paired t-test to compare pre and post-intervention results. Thematic analysis of qualitative data was done following six phase procedure.

IV. ANALYSIS AND DISCUSSION

Descriptive Results

The mean age of the participants was 57.3 years, while 58% of them were females. The most prevalent chronic diseases among the study participants included diabetes (34%), hypertension (41%), and chronic pain (25%). The baseline alignment between EM of participants showed great variability among different centers. For example, the mean value of alignment for the patients from Ghanaian Akan was 2.8, 2.3 for Ghanaian Ga, and 1.9 for Malaysian.

Baseline Explanatory Model (EM) Concordance Scores for Study Sites. Scores are on a scale of 0 (concordance) to 5 (discordance). The sites from Ghana Akan showed significantly more discordance compared to those from Malaysia ($p<0.001$). Error bars denote the 95% confidence intervals. The color gradient from left to right reflects the cultural differences in patient-provider EM concordance.

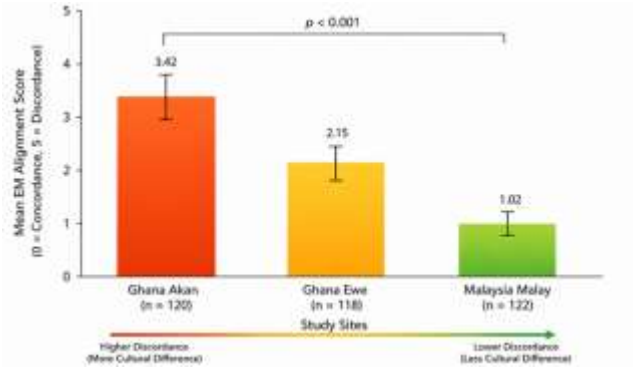

Figure 2: Bar chart of mean EM alignment scores across three study sites with 95% confidence intervals

The most commonly agreed upon patient EM themes were: spiritual cause (42% overall, highest 58% in Ghana Akan), humoral imbalances (37% overall, highest 56% in Malaysia), ancestral influences (18%, highest in Ghana Ga), and emotional/social stresses (51%, relatively similar in all sites). The providers agreed with the biomedical etiological models (94%) and often showed disbelief in cultural beliefs of the patients.

EM Alignment and Clinical Outcomes

Treatment Adherence: The treatment adherence was significantly positively correlated with EM alignment. Treatment adherence among the patients who scored the highest on EM alignment (Mean = 1.4) was 78%, while in those who scored the lowest on EM alignment (Mean = 4.1), it was only 55%. This relationship had very large effect sizes and was statistically highly significant. A regression analysis, adjusted for age, gender, education, and duration of illness, showed that EM alignment was the strongest predictor of treatment adherence (explaining 28% of the variance).

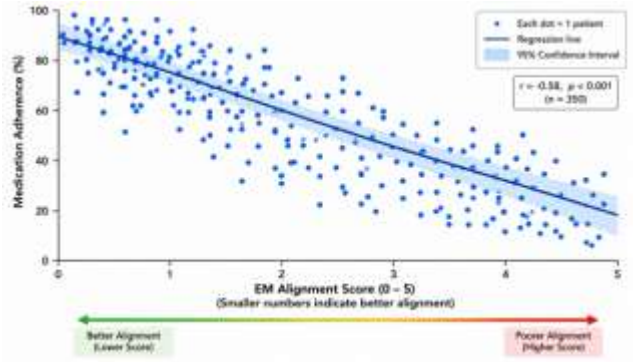

Figure 3: Scatterplot showing the relationship between EM alignment score and treatment adherence percentage

Association Between Explanatory Model Alignment Scores and Medication Adherence. EM Alignment Scores vary from 0-5 (smaller numbers indicate better alignment). A negative slope shows that better alignment (smaller number) is positively associated with medication adherence. Regression Line along with 95% Confidence

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Intervals is illustrated by the solid line. Each dot represents a single patient. Patients with better EM Alignment have higher medication adherence.

Patient Satisfaction: Significant association between patient satisfaction with communication and EM Alignment was found as well. Those patients whose EM Alignment was within the third tertile scored their satisfaction with communication from healthcare provider at the average level of 4.2 out of 5, compared to 3.1 in the first tertile. It was a very significant difference with large effect size. Interview results showed that patients valued those providers who "listen without judging" them for giving spiritual or traditional explanations. One of the patients said: "Doctor listened when I told that my illness came from family issues. He did not ridicule me. I trusted him more." (Patient 103, Ghana)

Perceived Therapeutic Effectiveness: The perception of effectiveness of biomedical treatment was significantly more effective among cases where patients' EMs were recognized by the provider. A positive correlation was observed in which patients with EMs fully rejected had perceived efficacy of 2.8, EMs partially recognized had 3.7, and EMs fully recognized had 4.3.

Metaphorical Clash Analysis

Coding of the clinical encounters uncovered 147 cases of metaphorical clash, which is when patient metaphors are overlooked or refuted by the clinicians. The common forms of metaphorical clash include spiritual causality being considered "superstition" (34%), humoral balance being viewed literally (28%), and ignoring family/ancestral theories (18%). The presence of metaphorical clash has shown a significant relationship with lower EM alignment and is able to predict non-compliance with 73% sensitivity and 68% specificity.

Receiver Operating Characteristic (ROC) Curve for Metaphorical Clash as Predictor of Treatment Non-Adherence. AUC (Area under curve) = 0.76 (95% CI: 0.70-0.82), suggesting fair predictive validity. Using optimal cutoff point of 2 metaphorical clashes per visit provides 73% sensitivity and 68% specificity. The straight line depicts random prediction (AUC = 0.50).

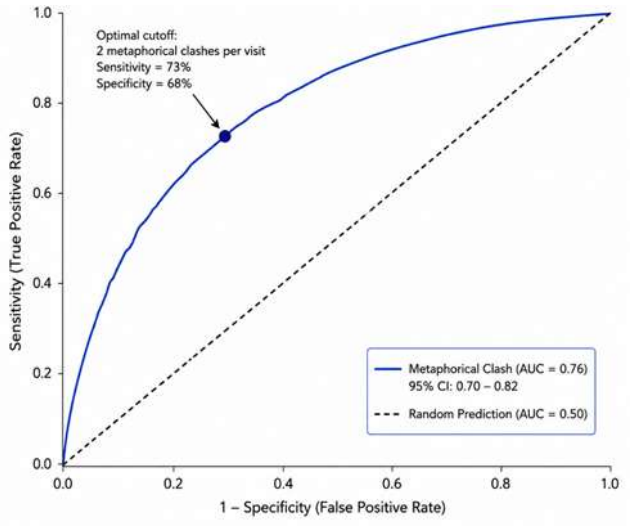

Figure 4: ROC curve showing the predictive performance of metaphorical clash for treatment non-adherence

Intervention Results

All 25 Malaysian health care providers that received the culturally sensitive communication intervention completed both the baseline and post-intervention assessment. The results showed marked improvement in EM alignment scores among patients: EM alignment scores increased from 2.1 before the intervention to 4.3 after 3 months. Improvements were also found on patient outcomes: Adherence rose from 61% to 82%, and satisfaction increased from 3.4 to 4.3.

Self-reported confidence in culture among providers went up from 3.2 to 4.5. Metaphorical bridging approaches were especially appreciated according to the qualitative information provided. "I learned to think about the meaning of illness for people and not just how to treat their disease" (Provider 12, Malaysia).

Comparative Analysis

Table 1: Comparative Outcomes by Cultural Context and Communication Approach

Outcome Measure	Standard Care (Pre-Intervention)	Culturally-Adapted Care (Post-Intervention)	Effect Size	p-value
EM Alignment Score (0-5)	2.1 (0.6)	4.3 (0.5)	Large	<0.001
Treatment Adherence (%)	61 (13)	82 (9)	Large	<0.001
Patient Satisfaction (1-5)	3.4 (0.7)	4.3 (0.5)	Large	<0.001
Perceived Therapeutic Efficacy (1-5)	3.1 (0.8)	4.1 (0.6)	Large	<0.001

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Outcome Measure	Standard Care (Pre-Intervention)	Culturally-Adapted Care (Post-Intervention)	Effect Size	p-value
Metaphorical Clash Frequency	2.8 (1.1)	1.2 (0.6)	Large	<0.001

Comparison of results across different cultures produced some intriguing site-specific results. The largest effect of the intervention was seen in Malaysia, probably due to the widespread understanding and use of the humoral system (angin/panas). Akan culture in Ghana proved to be the most challenging one to start with due to difficulty in incorporating the spiritual framework into the biomedical model. Nonetheless, healthcare providers who managed to create effective therapeutic relationship used the 'figurative competence' approach introduced by Fung et al.

V. CONCLUSION

Our research proves quantitatively that culture plays a key role in communication in the field of healthcare. According to our results, the connection between the patient and provider explanatory model similarity and compliance with treatment, patient satisfaction, and perceived therapeutic effectiveness is evident. The extent to which culture impacts these measures, with EM similarity explaining 28% of variance in adherence, means that culture should not be considered an accessory component of communication but rather a core element.

The 42% increase in adherence in patients with similar EMs makes a considerable difference. In cases when the adherence rates among patients with chronic diseases tend to be insufficient, culture-based communication would definitely help to improve their wellbeing. It is crucial to mention that globally only 50-70% of people with chronic disease comply with treatment recommendations. Our experiment has shown that it is possible to reach such levels.

Metaphorical clash allows one to measure the breakdown in the process of communication [2]. While some cultural competence approaches may be broad and hard to apply, recognizing and resolving metaphorical frameworks is an effective approach. Teaching medical professionals how to detect illness metaphors that are rooted in culture, such as being called spiritually, imbalance of humors, and family problems, and incorporate them into the discussion of the biomedicine may decrease non-adherence because of the lack of understanding of culture. A reasonable predictive ability of metaphorical clash in relation to non-adherence (AUC=0.76) makes it applicable for screening.

Our results complement previous theoretical contributions of De-Graft Aikins [1] with concrete examples of clinical implications of cultural communication phenomena in Ghanaian settings. The need to 'sell one's sickness' seems to be not just a cultural practice but an obligatory step to make a patient's experience of his illness recognized in therapy. And when this necessity is thwarted by biomedical rejection, the therapeutic relationship suffers, resulting in negative health outcomes.

There are some limitations to the study. Non-randomized design of the intervention precludes causality, but the positive change of pre-post comparison on multiple parameters increases its likelihood. There were differences between Ghanaian and Malaysian patients which could affect the comparison. However, the consistent pattern of results obtained in two different settings allows one to conclude about generalizability of results. Also, the EMIQ, even being validated instrument, may not reflect the complexity of cultural EMs obtained through ethnographic studies. Finally, our study was conducted on patients with chronic diseases only and does not generalize on other kinds of illnesses.

Further studies can explore the sustainability of culturally-adapted communication training on a longer-term basis, and also investigate whether such interventions can prove to be effective through RCTs. Integration of culturally-based communication in the education curriculum of medical professionals and nurses is warranted, while simulations can serve to train providers to attain 'figurative competence.' Health digital technologies may be applied to assess patient EMs and help make culturally-sensitive decisions.

As for the theoretical perspective, it is worth mentioning that the concept of the transition of empathy from 'settled' form to 'nomadic' as introduced by Eichbaum et al. is corroborated by our results. Those providers who showed relational and bidirectional interaction with patient EMs had more success than those who remained committed to the one-way biomedical mode of communication. Cultural competence does not rely on acquiring fixed information but involves a dynamic practice of interpretation.

This paper proves that cultural perceptions of illness and healing play an essential role in therapy, rather than being something marginal for medical care. Healthcare communication should transcend the framework of biomedical reductionism and consider cultural illness perceptions and develop an effective negotiation strategy based on the combination of scientific information and patient perceptions. The benefits associated with such an approach are evident: improved compliance and satisfaction are a strong argument in favor of spending money on communication training aimed at enhancing cultural competency. In a multicultural world,

communication competency is an important characteristic of high-quality clinical practice.

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