

# 'Multicultural Clinical Interactions: The Importance of the Explanatory Model (EM) Concept in Understanding the Cultural dimensions of Clinical Practice'

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## **ABSTRACT**

Conceptual models from meaning-centred medical anthropology such as the 'explanatory model' (EM) can provide both researchers and health professionals with important insights into the cultural dynamics of the health care encounter. Clinical interactions between health practitioners and patients can be constructed as transactions between explanatory models, the compatibility of which may have negative consequences for patient satisfaction and the quality of care. This paper explores the clinical case of Lia Lee, a Hmong child with a seizure disorder to explore the explanatory model concept and some of the dimensions of 'multicultural clinical interactions'.

## **KEYWORDS**

Culture, Explanatory Model (EM), Multicultural Clinical Interactions

## **INTRODUCTION**

Culture is not only an integral influence on everyone's life, "it is a part of every personal encounter and every interaction-including every clinical interaction" (Fitzgerald, 1992, pg. 38). As Hoeman (1989) has pointed out, the provision of health care to every patient, no matter what their ethnic origin may be, involves the interplay of multiple cultures. Cultural beliefs about health and illness are intimately linked to how patients and their practitioners communicate (Hahn, 1995; Helman, 2007) during the clinical process. Culture influences how we define health, how we manifest illness and how we decide upon the most appropriate course of action or treatment (Kleinman, 1980). The influence of culture extends to the

expectations that we have of health services or healing practices and in the context of the clinical process, the expectations that the practitioner and patient have of one another (Mullavey-O'Byrne & West, 2001). There are numerous definitions of culture, which is perhaps a reflection of its fuzzy conceptual nature. Indeed, one is reminded of Clifford Geertz's (1973, pg. 4) classic assertion about the ambiguous nature of culture, that it "obscures a good deal more than it reveals". Central to most definitions however, is the idea that culture is the learned, shared, patterns of beliefs, values, attitudes and behaviours characteristic of a society or population (Ember & Ember, 1988). If these beliefs, values, attitudes, and behaviours are not

shared by others they are not cultural; they are idiosyncratic, reflecting an individual's personal adaptive style or personality (Fitzgerald, 1992).

Conceptual models from meaning-centred medical anthropology<sup>1</sup> (Good, 1994) such as the 'explanatory model' (EM) concept (Kleinman, 1980; Kleinman, Eisenberg & Good, 1978) can provide clinical practitioners with important insights and understandings regarding the multicultural dynamics of their health care encounters with patients and their families. According to the psychiatrist and medical anthropologist Arthur Kleinman (1980, pg. 105), explanatory models are the "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process, whether patient or clinician". They refer to the culturally based explanations, aetiological mechanisms and expected treatment response to a perceived illness (Kleinman, 1980). Multicultural clinical interactions (Fitzgerald, 1992; Fitzgerald et al., 1997) between practitioners and patients can be constructed as transactions between explanatory models, the incompatibility or disconfirmation of which may have negative consequences for the patients' and health professionals' satisfaction with the standard of care and clinical process.

This paper uses the clinical case study of Lia Lee (Fadiman, 1998), a Hmong child with a seizure disorder to explore the explanatory model concept and some of the dimensions of multicultural clinical encounters. As the analysis of Lia Lee's case will demonstrate, appropriate and therapeutic health care that is satisfying to service users and their families and, at the same time satisfying to health professionals, can occur only if the multiplicity of cultures is taken into account (Fitzgerald, 1992). The ideas

presented in this paper are not peculiar to people with certain kinds of illnesses or certain population groups. Indeed, they are applicable to all clinical encounters between practitioners, patients, and their families, and should form a base upon, which culturally appropriate health care can be developed at both micro (clinical) and macro interactional levels (organisational).

### **The Basis of 'Multicultural Clinical Interactions'**

In every clinical interaction involving a health professional and patient (in many cases this also involves the patients' family) there are at least three cultural systems involved: (a) the personal or familial culture of the health practitioner, (b) the personal or familial culture of the service user, and (c) the culture of the primary medical system<sup>2</sup> (Fitzgerald, 1992; Fitzgerald et al., 1997). In some circumstances, a fourth cultural influence, the traditional or folk medical culture of the patient or health professional should also be considered (Fitzgerald, 1992; Winkelman, 2009).

The personal or familial culture of the patient and health practitioner is multifaceted, encompassing linguistic, religious, educational, socio-economic and many other dimensions of cultural difference that intersect and manifest themselves in complex forms (Helman, 2007). Furthermore, in the process of becoming a health professional, practitioners undergo another socialisation process. They become socialised into a biomedical health culture, one which may involve somewhat different knowledge, beliefs, values, and attitudes than their personal or familial culture (Fitzgerald, 1992; Hahn, 1995). Indeed Good and colleagues (2003) have shown how student doctors learn to embody a 'medical gaze', which emphasises the dismantling of the patient's life narrative. Such life stories are deemed as

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<sup>1</sup> The meaning centred approach to medical anthropology emphasises social constructivist approaches to understanding health problems, illustrating the roles of social and cultural processes in defining, interpreting, and responding to maladies (Winkelman, 2009).

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<sup>2</sup> The primary medical system in Western societies such as the UK tends to be dominated by 'biomedicine'. Biomedicine refers to the healing traditions based upon the practices of physicians (M.D's) and scientific medicine; also known as 'allopathic' or 'cosmopolitan' medicine (Winkelman, 2009).

inadmissible evidence; patient's experiences of illness (including their social and cultural context) become reconstituted into medically meaningful narratives. The clinical case study of Lia Lee discussed in a later section of this paper will highlight the consequences of not taking the cultural and psycho-social context into account.

Thus, all health care encounters involve the multiple interplay of cultures (Fitzgerald, 1992). The result is that, "people enter into a multicultural interaction wearing multiple cultural lenses" (Fitzgerald et al., 1997, pg. 19). However, the amount of overlap in the participants' cultural knowledge in any particular health care encounter can vary considerably. Moreover, the greater the cultural knowledge shared among the participants in any given clinical encounter, the less likely there is to be a cultural misunderstanding (Fitzgerald, 1992). For instance, people who grow up in societies where biomedicine is the primary medical culture, will usually have some knowledge of this medical culture. However the degree of awareness varies considerably from one person to another. When the participants in a clinical encounter have little shared knowledge of each other's cultural system, the outcome usually results in the 'disconfirmation of cultural expectations' and dissatisfaction with the quality of care (Brislin, 2000). Multicultural interactions can be viewed as transactions between the health professionals' and patients' 'explanatory models' (EM) (Fitzgerald, 1992; Kleinman, 1980). The compatibility of these explanatory models has consequences for the quality of the health care interaction.

### **Explanatory Models and the Multicultural Healthcare Encounter**

In his seminal piece of work, *'Patients and Healers in the Context of Culture'*, Kleinman (1980) outlined five major issues, which explanatory models (EM) seek to answer in relation to a specific episode of illness: (1) aetiology or causation; (2) time and mode of the onset of symptoms; (3) patho-physiology (4) course of the illness (which includes the appropriate illness behaviour, 'sick role' and level of severity of the disorder); and

(5) appropriate treatment response. Patients and practitioners both employ explanatory models in any given multicultural health care encounter (Fitzgerald, 1992; Kleinman, 1980). While the explanatory models of health professionals tend to address most or all of these aforementioned five factors, patient models invariably deal with what are perceived at the time to be the most pressing and salient issues (Kleinman, 1980).

Explanatory models are also common to all groups of people and therefore, have an underlying cultural basis (Kleinman, 1980). They are embedded in larger cognitive systems, which are derived from and constructed by cultural and social structural arrangements (Good & Good, 1981). Thus, patients' and health professionals' explanatory models "share a common body of meanings with members of their subcultural group", which in turn is influenced by the wider contextual web of shared meanings, referred to as 'semantic illness networks' (Good & Good, 1981).

The explanatory model provides a template for dealing with and understanding any clinical interaction between practitioner and patient (Fitzgerald, 1992; Fitzgerald et al., 1997). An explanatory model, particularly the aetiological component of the explanation, attempts to answer some fundamental questions. For example, why it happened to that particular person at that particular time and in that particular way? Why this illness or injury? Why it came to happen or what caused it? What should happen over the course of time? What should be done about it? Explanatory models draw on "a wide range of premises about the nature of persons and social behaviour, which do not pertain solely to illness or even abnormality" (White & Marsella, 1982, pg. 5). Patients and practitioners often have different explanatory models about any given episode of illness. To quote Hahn (1995, pg. 265), patients and practitioners "inevitably conceive of the world, communicate, and behave in ways that cannot be reasonably or safely assumed to be similar or readily compatible". Conflicts may occur in the health professional-patient relationship due to the incompatibility of explanatory models.

One of the main reasons why Kleinman's (1980) explanatory models concept has become so influential in the disciplinary field of medical anthropology is its emphasis on the need for health professionals and patients to negotiate their 'clinical realities' or 'social constructions of illness' (Kleinman, 1980). The need for health professionals and patients to negotiate their explanatory models of illness was also highlighted in a clinical study, which examined the clinical interactions between psychiatrists and their patients (Callan & Littlewood, 1998). In particular, Callan and Littlewood's findings highlighted that the most significant association with both practitioner and patient satisfaction with the clinical encounter was the concordance between their explanatory models. If healthcare professionals are to understand why their decision making behaviour does not correspond with the expectations of their patients, they need to understand that their explanatory models may not always be compatible with that of their patients (Fitzgerald, 1992). According to Kleinman and Benson (2006, pg. 1674), "explanatory models ought to open clinicians to human communication and set their expert knowledge alongside (not over and above) the patients' own explanation and viewpoint". If the health practitioner is to make some sense of their patients' illness experience<sup>3</sup>, the elicitation of the patients' explanatory model should therefore, occur at every stage of the clinical process (Kleinman & Benson, 2006). The negative consequences of an incompatibility of explanatory models is now demonstrated in the clinical case of Lia Lee, a Hmong child with seizure disorder.

### **The Clinical Case of Lia Lee**

Ann Fadiman's (1998) seminal book, 'The spirit catches you and you fall down', tells

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<sup>3</sup> According to Kleinman (1980), the anthropological conception of 'illness' refers to a patient's experience of something wrong, a sense of disruption in well-being that may be the result of disease or caused by cultural beliefs (e.g., the belief that one is being persecuted by witches).

the tragic tale of Lia Lee, a Hmong<sup>4</sup> child with seizure disorder, who lived in Merced, California. Lia's parents and medical doctors both wanted the best quality of care for Lia, however their ideas about what caused her illness and its appropriate treatment were very different. In effect, their explanatory models (Kleinman, 1980; Kleinman, Eisenberg & Good, 1978) of Lia's condition were incompatible. While the Hmong tend to view all illness and healing as spiritual matters that are linked to virtually everything in the universe, by contrast, Lia's doctors diagnosed her condition as 'Epilepsy', a severe medical condition, one that was evident from the abnormal electrical activity spreading across her brain with increasing frequency.

In an attempt to control the severity and frequency of Lia's seizures her doctors had prescribed a complex regime of anticonvulsant medication. However, Lia's parents had believed that the cause of their daughter's seizures was not Epilepsy, but 'Soul Loss'. According to Hmong cultural belief, 'Soul Loss' is thought to occur when the soul has either left the body on its own or been stolen, leaving the body in a weakened and vulnerable ill state. During the course of Lia's illness her parents did everything they could in accordance with the logic of their cultural beliefs to help her. They not only consulted with medical professionals, but also took Lia to a clan leader and shaman within the local Hmong community, sacrificed animals, and brought expensive amulets to guide her soul's return. Because of their beliefs about the cause of their daughter's illness, the complexity of the anticonvulsant drug therapy and its adverse side effects, Lia's parents did not comply with the regime of prescribed medication. Lia's parents believed that they were doing all they could do to ensure their daughter's welfare, however, the doctors responsible for Lia's medical treatment believed that her parents were endangering her life by not giving her the prescribed medication. The doctors had called child protective services, and Lia was placed into secure foster care. The ways in which Lia's parents and the local

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<sup>4</sup> The Hmong are a Southeast Asian ethnic group from the mountainous regions of China, Vietnam, Laos, and Thailand.

Hmong community had viewed her condition and her medications as something, which exacerbated the seizures were never taken into account by the medical doctors. A coma-inducing seizure was eventually the outcome of the cultural differences between the medical doctors and Lia's parents.

(Adapted from Fadiman, 1998)

### **'Explanatory Models' and the Cultural Dimensions of Lia Lee's Case Study**

The way that different cultures or explanatory models (Kleinman, 1980; Kleinman, Eisenberg & Good, 1978) come together during the clinical process was illustrated in the clinical case study of Lia Lee. From the analysis of Lia Lee's case it was clearly evident that Lia's parents had a completely different aetiological understanding of their child's seizures than that presented by the medical doctors. For the Hmong believe that the life-soul, particularly that of babies and infants, can be stolen by the spirits, wander off, or become separated by being startled by a loud noise or through anger, grief, or fear. Lia's parents had thus believed that the loss of her soul was the cause of her seizures. Although medical practice lacks a similar aetiological category, 'catatonic schizophrenics' have been described metaphorically as 'bodies with no one home' (Galanti, 2008).

In addition, Lia's parents believed that the fleeing of their daughter's soul was the main determinant factor behind the timing and onset of their child's seizures. According to Lia's parents, her soul had become startled and subsequently fled when her sister had loudly slammed the door (Fadiman, 1998). The Hmong believe that the life soul of babies and infants is particularly vulnerable to being separated when startled, such as by a loud noise. Lia's parents also presented quite a different perspective on the course of Lia's illness to that conveyed by her medical doctors. For Hmong people such as Lia's parents, soul loss is perceived as a 'divine calling'. For Lia's parents and the wider Hmong community, this divine calling was evident in the symptoms of lengthy convulsions and periods of unconsciousness. While a source of concern; the condition that had afflicted Lia was also something that was seen to

bestow honour and distinction. It was potentially a blessing that could set Lia along the path to becoming a respected healer in her local community. However, for Lia's medical practitioners, the lengthy convulsions and periods of unconsciousness were signs and symptoms of a severe medical condition called Epilepsy. One that was evident in the brain scans, which showed abnormal electrical activity in Lia's brain (Fadiman, 1998).

Another important point should be made regarding the explanatory models used by Lia's doctors and parents to account for her seizures. The treatment response must be appropriate to the perceived cause of the illness episode (Kleinman, 1980; Kleinman, Eisenberg & Good, 1978). Thus, if as the Hmong believe the soul can leave the body, the goal of the treatment should be to return the soul to the body. It usually requires a sacred healer such as a shaman who can 'leave' his or her own body to search for and return the missing soul (Fadiman, 1998). The mind is very powerful, as the 'placebo effect' demonstrates, and therefore, the patients' or their family beliefs, as well as the physical body must be treated (Kleinman, 1980; Winkelman, 2009). For example, many British people feel they have not been treated properly if they do not receive an antibiotic for a virus, even though antibiotics are effective only against bacteria. Psychologically they need the prescription of antibiotics to get well (Helman, 2007).

To summarise, the problems that occurred in the clinical case of Lia Lee resulted from an incompatibility of explanatory models. Lia's doctors were trying to treat a 'disease', which they labeled as epilepsy, while her parents were concerned with an illness resulting from a 'lost soul'. The same symptoms had very different meanings in two very different cultural systems. The failure of Lia's doctors to negotiate with the explanatory models of her parents ultimately resulted in the non-adherence to the prescribed anticonvulsant medications.

### **Conclusion**

Culture is part of every personal encounter and every interaction-including every clinical interaction. (Fitzgerald, 1992). The

provision of care no matter what the ethnic background of the health practitioner and service user involves the multiple interactions of cultures and frames of reference. Clinical interactions between patients and their health practitioners inevitably involve the transaction of explanatory models. Explanatory models (EM) are the culturally based notions about a specific episode of illness. Thus, explanatory models are always cultural constructions of clinical reality. The way that different cultures or explanatory models come together in a clinical interaction was aptly demonstrated by the case of Lia Lee, a Hmong child suffering from the affects of a 'seizure disorder'. Lia's parents explanatory model of 'soul loss' was very different from the doctors' conceptualisation of the illness as epilepsy or disruption of the electrical signals in the brain. This clinical case also demonstrated how the aetiological component of an explanatory model determines the required treatment response. The concept of explanatory models is also introduced in this paper as a framework for health providers to use in discovering their patients' illness beliefs and their cultural expectations regarding the malady and its treatment.

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