

Editorial

# Three Communication Tips to Integrate Psychological and Cultural Determinants Into Everyday Hospital Care

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## 1. Introduction

Internists routinely help to manage inpatient presentations where distress and context shape symptom burden, engagement, and recovery, especially when trajectories feel unclear, symptoms persist despite reassuring tests, or care becomes repetitive and frictional. The biopsychosocial model is not controversial. The practical challenge is the pace: ward rounds prioritise physiology, investigations, discharge targets, and bed flow. Crucially, meaningful integration does not require a full “mental health assessment”. Small, structured communication choices can yield disproportionate benefits: fewer missed cues, less conflict, better shared understanding, and earlier identification of risk. These communication tips also help when culture shapes how distress is communicated [1]. In some contexts, naming emotions is discouraged; distress may be communicated as bodily pressure, fatigue, dizziness, “weakness”, or non-specific pain [2]. In other contexts, patients may expect a strongly biomedical explanation and experience psychological questions as dismissal [3]. A culturally attuned approach is therefore not an “extra”; it is often the shortest path to a workable plan [4].

Culture can also influence illness behaviour and explanations of causation in ways that matter on the ward. For example, some patients from Indigenous communities (e.g., Aboriginal and Torres Strait Islander peoples in Australia, Māori in Aotearoa New Zealand, or First Nations peoples in Canada) may understand illness through relational, spiritual, and community frameworks, and may value family involvement, community supports, or culturally safe services as part of care; a purely biomedical framing may feel incomplete even when it is clinically necessary [5]. Among some migrant groups, prior experiences of conflict, displacement, racism, or insecure legal status can shape how hospital questions are interpreted (e.g., heightened fear of bad news, reluctance to disclose distress, or preference for a concrete biomedical explanation to avoid stigma) [6]. Conversely, some patients may readily accept stress-related mechanisms but prefer non-psychiatric language (e.g., “nervous system overload” or “sleep and recovery”) to preserve legitimacy and reduce shame [7]. These

are not fixed group traits; they are reminders that a brief check of the patient’s own explanatory model and preferred language can quickly reduce misalignment and improve engagement.

Below are three communication tips that fit within routine inpatient reviews (often under a minute each) and are useful when things feel “stuck”: persistent symptoms without a trajectory, repeated attendance, discordant narratives within the team, refusal of tests, high worry, or impairment that the “medical story” alone does not explain.

## 2. Communication Tip 1: Start With Function, Not Feelings

When time is tight, asking “How are you coping?” can sound vague, and “Are you anxious?” can shut the conversation down. Function-focused questions are faster, less culturally loaded, and often reveal distress indirectly. For example:

- “How has your sleep been in the hospital? Any nights with hardly any sleep?”
- “Are you managing to eat and drink, or has your appetite dropped?”
- “When the symptoms hit, what can’t you do that you normally can?”
- “What’s been the hardest part of today?”

Function is also clinically relevant: sleep loss predicts poorer pain tolerance, delirium risk, and reduced participation in physiotherapy; appetite and energy affect recovery; inability to do basic tasks signals severity. Patients who would never say “I feel low” may readily say “I can’t switch my mind off”, “I’m exhausted all the time”, or “I’m scared to move”.

If the function suggests significant distress, you can then bridge gently. For example:

- “A lot of people in your situation notice their body and mind affecting each other. Would it be okay if I ask one or two quick questions that help us support recovery?”

At this point, brief validated screeners can be used when appropriate and feasible, such as Patient Health Questionnaire-2 (PHQ-2) or Generalised Anxiety Disorder-2 (GAD-2) (as a clinical aid, not a label). Even without



formal tools, function-first questioning can flag symptoms such as panic, driving chest symptoms, insomnia perpetuating fatigue, or demoralisation affecting engagement.

### 3. Communication Tip 2: Elicit the Patient's Explanatory Model in 30 Seconds

Kleinman's classic insight remains practical: patients always have an explanation, even if it is unspoken [8]. Misalignment between the clinician's and patient's explanatory models drives conflict ("They think it's stress"), refusal ("I don't need mental health support"), and repeated attendance ("No one found the real cause"). You do not need a long cultural interview to reduce this misalignment; one or two prompts can do it. For example:

- "What do you think is happening in your body?" to understand their meaning.
- "What worries you most that this could be?" to understand their fear.
- "Why do you think this is happening now?" to understand their context.
- "What were you hoping we could do for you today?" to understand their expectation.

These align closely with the spirit of the Cultural Formulation Interview to understand the patient's definition of the problem, perceived causes, supports, and preferred help [9]. They are also compatible with an "ICE" approach (ideas, concerns, expectations) commonly used in UK practice [10].

When culture shapes expression, these questions help translate symptoms into meaning. A patient describing "pressure in the chest" may be expressing panic, grief, or family conflict in a culturally acceptable bodily register. A patient reporting "tiredness everywhere" may be carrying caregiver burden, migration stress, or stigma about mental health. The clinician's job is not to decide "psych vs medical", but to hold both possibilities while keeping the patient's experience legitimate.

A useful response frame may be "Validate + Link + Plan" such as: "That sounds frightening. The tests we're doing help rule out dangerous causes. At the same time, the body can produce very real symptoms when the nervous system is on high alert. Let's make a plan for both: finishing the medical checks and supporting sleep and anxiety so your body can settle."

### 4. Communication Tip 3: Normalise the Mind-Body Link and Give a Next Step

Some patients hear psychological questions as dismissal. The antidote is a brief, physiological explanation that preserves legitimacy and leads to action.

A 20-second normalisation can help:

- "These symptoms are real. When the brain's threat system is activated by illness (or pain, uncertainty, or stress), it can amplify sensations like tightness, breathless-

ness, dizziness, and fatigue. That doesn't mean it's all in your head. It means your body is trying to protect you."

Then offer one concrete next step, such as:

- Immediate symptom relief: breathing pacing, grounding, sleep-protective advice, pain coping strategies.
- Micro-screening: "Two quick questions help us see if low mood or anxiety is adding weight to the symptoms." (PHQ-2/GAD-2).
- Team linkage: "If you're open to it, our liaison colleagues can help with strategies while we continue the medical plan."
- Discharge safety: ensure follow-up, written plan, clear red flags, signposting to General Practitioner (GP)/community services.

This is also where culture matters: "mental health" language can trigger shame or avoidance in some patients [11]. Where helpful, you can substitute "stress system", "nervous system", "sleep and recovery", or "coping load", depending on what the patient finds acceptable (while still offering evidence-based support). In hospital settings, where medication changes are common, framing matters: a low-dose agent for sleep/anxiety may be easier to accept if described as supporting the nervous system during acute illness, alongside non-pharmacological measures.

If a communication tip reveals intense distress, keep it brief and contain: acknowledge ("That sounds really hard"), offer choice ("Would you prefer one minute now, or someone to come back later?"), do a quick safety check if indicated, and bridge to next steps (liaison/psychology, nursing support, a sleep/pain plan, and clear discharge safety-netting). The goal is containment and a clear plan, not a longer interview on the ward round.

### 5. A Practical One-Minute Tool

Table 1 offers one-minute ward prompts for "stuck" encounters: unclear trajectories, persistent symptoms, difficult engagement, or marked but unspoken distress.

### 6. When to Escalate (and How to Do It Cleanly)

Communication tips are not a substitute for specialist input. Escalate when there is (a) clear risk (self-harm concerns, severe agitation, psychosis, suspected delirium); (b) complex trauma or safeguarding concerns; (c) severe functional impairment out of proportion to medical findings; (d) treatment refusal creating imminent harm; or (e) repeated admissions with entrenched distress and no shared formulation. When you do refer, frame this in non-stigmatising, medically integrated terms. For example: "They're part of the medical team that helps with sleep, distress, and coping during illness; it often supports recovery and can help care move forward."

**Table 1. One-minute prompts and responses for common inpatient scenarios.**

Scenario	Quick prompt	What it may reveal	Clinician micro-response (Validate + Link + Plan)
Persistent non-specific symptoms (fatigue, pain, dizziness)	“When it’s worst, what can’t you do?”	Functional impairment; hidden distress; sleep disruption	“Let’s target what’s limiting you most (sleep, movement, appetite) alongside the medical checks.”
Chest tightness/breathlessness with reassuring tests	“What’s the worst thing you fear this could be?”	Catastrophic interpretation; panic; prior trauma	“We’re ruling out dangerous causes. The body can mimic heart/lung symptoms when the threat system is on. Here’s what we’ll do next...”
Frequent attendance/repeated investigations	“What do you feel you haven’t had explained yet?”	Unmet explanatory need; mistrust; cultural expectations	“Thank you, let me summarise what we know, what we’ve ruled out, and what we’re watching for. Then we’ll agree a plan.”
Refusal of tests/treatment	“Help me understand what concerns you about this test/treatment.”	Beliefs, stigma, religious/cultural concerns, fear of diagnosis	“That makes sense. Let’s adapt where we can and keep you safe. What would feel acceptable?”
Very quiet/stoic patient	“Many people don’t talk about emotions, but illness still affects sleep and concentration. How are those?”	Cultural restraint; depression/anxiety expressed somatically	“We can support recovery without forcing emotional talk. Small changes can make a difference.”
Family conflict or high expressed emotion	“Who is your main support, and what would be most helpful for them to hear from us?”	Support gaps; caregiving burden; communication needs	“Let’s align everyone on the plan and what to expect. This often reduces stress for everyone.”

## 7. The Hidden Efficiency of Humanistic, Culturally Attuned Care

Clinicians understandably worry that “whole-person care” costs time. In practice, it often saves time by reducing circular conversations, repeated reassurance, conflict, and avoidable re-attendances [12]. A patient who feels believed is more likely to accept a stepped plan [13]. A patient whose fear is named is less likely to keep searching for a single test to end uncertainty [14]. A team that shares a simple formulation (for example, “high anxiety alongside acute illness”) communicates more consistently [15].

Culturally aware practice means recognising that culture can shape symptoms, expectations, and communication; asking patients about their context rather than relying on assumptions fits internal medicine because it improves diagnostic reasoning under uncertainty. It also protects clinicians from frustration and burnout: when a case feels stuck, a brief shift from “Why won’t this resolve?” to “What meaning does this symptom carry for them?” can reopen options.

These communication tips are small by design: they fit the pace of inpatient care, support safer decision-making, and help teams reach a shared plan, especially when culture shapes how distress is communicated. The aim is not to turn internists into mental health specialists, but to make routine reviews slightly more human, and therefore more efficient.

## 8. Conclusion

What slows ward care is not complexity alone, but misalignment between symptoms and meaning; risk and reassurance; tests and expectations. These brief communication tips help create alignment quickly. They preserve legitimacy, surface what matters, and translate uncertainty into a shared plan. In that sense, integrating psychological and cultural determinants is not an added layer of care; it is often the simplest way to move care forward.

### Key Points

- Hospital medicine is fast, but psychologically and culturally attuned care can be integrated through brief, structured communication tips that often take under a minute.
- Starting with function (sleep, appetite, activity, and hardest moment) is a time-efficient and culturally flexible way to surface distress without forcing emotional labels.
- Eliciting the patient’s explanatory model (ideas, concerns, expectations) reduces misalignment that drives refusal, repeated attendance, and conflict, while preserving the legitimacy of symptoms.
- A brief mind–body normalisation, accompanied by one concrete next step (e.g., breathing pacing, micro-screening, liaison linkage, discharge plan), enhances shared understanding and facilitates action.
- These communication tips are not a substitute for specialist input, but they provide a clean bridge to esca-

tion when risk, severe impairment, safeguarding issues, or entrenched distress are present.

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Not applicable.

### Author Contributions

All elements of the study and subsequent write-up were carried out by the author [YK]. The author read and approved the final manuscript. The author has participated sufficiently in the work and agreed to be accountable for all aspects of the work.

### Ethics Approval and Consent to Participate

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