

FROM BLAME TO UNDERSTANDING: FILIPINO PARENTS' EXPLANATORY MODELS OF CHILDHOOD CONGENITAL ANOMALIES AND THE ROLE OF CULTURALLY RESPONSIVE NURSING

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ABSTRACT

Background: Congenital anomalies can profoundly affect children and their families. Parents' understanding of these conditions is shaped not only by biomedical information but also by family narratives, cultural beliefs, spiritual interpretations, and personal experiences. In the Philippines, culturally mediated explanations may coexist with biomedical accounts and influence parental emotions, healthcare-seeking, and interactions with healthcare professionals.

Objective: This study explored how Filipino parents understand and explain their children's congenital anomalies, focusing on culturally mediated explanatory beliefs, emotional responses, healthcare-seeking experiences, and interactions with healthcare professionals.

Methods: A qualitative descriptive design was employed. Eighteen parents of children with structural or genetic congenital anomalies participated in individual semi-structured interviews conducted between January and July 2025. Participants comprised 14 mothers and 4 fathers recruited from pediatric outpatient departments, tertiary referral hospitals, and community-based support networks. Interviews explored perceived causes of congenital anomalies, family and community beliefs, emotional responses, sources of health information, healthcare-seeking experiences, and encounters with nurses and other healthcare professionals. Data were analyzed using Braun and Clarke's reflexive thematic analysis. Reflexivity, an audit trail, repeated engagement with the dataset, and analytic discussions among the research team supported trustworthiness.

Results: Four themes were developed: (1) **Pluralistic Explanatory Models of Causality**, (2) **The PsychoCultural Burden of Causal Attribution**, (3) **Negotiating Parallel Systems of Care**, and (4) **Nursing Communication as a Bridge Between Cultural Meaning and Biomedical Care**. Participants described biomedical, hereditary, maternal, cultural, familial, and spiritual explanations that sometimes coexisted. Culturally mediated causal explanations could contribute to parental guilt, self-blame, stigma, and uncertainty, particularly when parents perceived the condition as preventable. Some participants described consulting traditional healers or maintaining spiritual practices alongside biomedical treatment. Respectful and understandable communication from healthcare professionals, particularly nurses, helped parents reconsider causal beliefs, reduce self-blame, and engage more constructively with care.

Conclusion: Filipino parents may negotiate multiple explanatory models rather than choosing exclusively between biomedical and non-biomedical explanations. Culturally responsive nursing should acknowledge the meaning of these beliefs while providing accurate information, addressing harmful misinformation, reducing parental blame, and supporting family-centered care.

KEYWORDS: congenital anomalies; explanatory models; cultural beliefs; cultural humility; qualitative research; family-centered care; nursing; Philippines

INTRODUCTION

Congenital anomalies comprise structural, functional, or metabolic conditions that originate during prenatal development and are present at birth. They remain an important cause of infant morbidity, mortality, and lifelong disability globally (Boyle et al., 2018; World Health Organization [WHO], 2023). For families, receiving a diagnosis may create substantial emotional, social, and financial challenges and may require parents to make complex decisions regarding treatment, rehabilitation, and long-term caregiving (Lotto et al., 2018; Mazibuko et al., 2022).

A diagnosis of a congenital anomaly also generates a need for explanation. Parents commonly seek answers to questions concerning why the condition occurred, whether it could have been prevented, whether they are

responsible, and what can be done for their child. These questions are not answered exclusively through biomedical knowledge. Parents interpret illness and health conditions through personal experiences, family narratives, cultural knowledge, spiritual beliefs, and interactions with healthcare professionals.

Kleinman's Explanatory Model Framework provides an important perspective for understanding this process. Kleinman (1980) proposed that individuals and groups develop culturally influenced understandings concerning the etiology, onset, mechanisms, severity, consequences, and appropriate treatment of illness. Such explanatory models influence how people interpret symptoms, communicate with healthcare professionals, and make decisions regarding care.

In the Philippine context, biomedical explanations may coexist with culturally transmitted beliefs and spiritual interpretations. Previous Philippine scholarship has documented beliefs involving maternal experiences, pregnancy-related behaviors, hereditary explanations, supernatural causes, and divine will. Concepts such as *lihi* or *pagdadahi* may be invoked to explain perceived relationships between maternal cravings or experiences during pregnancy and characteristics of the child. Other culturally familiar concepts, including *usog*, *kulam*, and spiritual explanations, may also form part of families' meaning-making processes (Jocano, 2003; Tan, 2008; Felipe-Dimog et al., 2022).

Importantly, culturally mediated explanations should not automatically be understood as irrational or simply dismissed as "superstitions." For parents, such explanations may provide a framework for understanding an unexpected event, maintaining continuity with family traditions, or finding spiritual meaning in a difficult experience. At the same time, when unsupported causal explanations lead parents to believe that their actions directly caused a congenital condition, they may contribute to guilt, shame, stigma, or anxiety.

Existing Philippine research has documented mothers' beliefs concerning the causes of birth defects. FelipeDimog et al. (2022), for example, identified biomedical and sociocultural explanations among mothers of children with birth defects in a Philippine tertiary hospital. This evidence establishes that culturally mediated causal beliefs are already an important component of the Philippine literature. However, less attention has been given to how parents negotiate multiple explanatory models in their interactions with healthcare professionals and how nursing communication may influence parental interpretations, emotional responses, and engagement with care. This distinction is important for nursing practice. Nurses frequently serve as the healthcare professionals who spend substantial time communicating with parents, explaining procedures, reinforcing treatment plans, providing emotional support, and facilitating family participation in care. When cultural explanations are dismissed without understanding their meaning, parents may experience shame or become less receptive to health education. Conversely, culturally responsive communication does not require nurses to endorse medically unsupported explanations. Rather, it requires nurses to understand the parent's perspective, acknowledge the emotional significance of the belief, and provide accurate information in a respectful and accessible manner (CampinhaBacote, 2002; Foronda et al., 2016; Foronda, 2020).

Accordingly, this study explored how Filipino parents construct and negotiate explanatory models of congenital anomalies, how these explanations relate to parental emotional experiences and healthcare-seeking, and how encounters with healthcare professionals—particularly nurses—shape parents' understanding and adjustment.

Study Objective

The study aimed to explore the explanatory models used by Filipino parents to understand their children's congenital anomalies, with particular attention to:

1. perceived causes and explanations of congenital anomalies;
2. cultural, familial, and spiritual beliefs surrounding causation;
3. emotional responses associated with causal interpretations;
4. healthcare-seeking experiences and the use of traditional and biomedical care; and
5. parents' experiences with nurses and other healthcare professionals.

METHODS Study Design

A qualitative descriptive design was used to obtain a comprehensive account of parents' experiences and interpretations in their everyday context. Qualitative description is appropriate when researchers seek a relatively low-inference account of participants' experiences while remaining attentive to the language and meanings participants use to describe a phenomenon (Sandelowski, 2000, 2010).

The study was informed conceptually by Kleinman's Explanatory Model Framework (Kleinman, 1980), which guided exploration of participants' understandings of causation, meaning, consequences, and treatment. Cultural humility was used as a nursing interpretive lens for considering how healthcare professionals can respond to culturally mediated explanations without stereotyping or endorsing medically unsupported claims (Foronda et al., 2016, 2020).

Participants and Setting

Participants were recruited from pediatric outpatient departments, tertiary referral hospitals, and community-based support networks in the Philippines.

Eligible participants were:

1. adults aged 18 years or older;

2. biological mothers or fathers who served as primary caregivers of a child diagnosed with a structural or genetic congenital anomaly; and
3. able to communicate in Tagalog, Taglish, or English.

Purposive sampling was used to obtain variation in participants' socioeconomic and educational backgrounds, children's ages, and types of congenital anomalies. A total of 18 parents participated, comprising 14 mothers and 4 fathers.

Rather than assuming statistical representativeness, the sample was considered in relation to the depth and relevance of the information generated for the study objectives. Recruitment and interviewing continued until the research team determined that the dataset provided sufficient depth and variation to address the study questions and that subsequent interviews were no longer substantially extending the developing patterns.

Data Collection

Individual, semi-structured interviews were conducted from January to July 2025. The interview guide was informed by Kleinman's Explanatory Model Framework (Kleinman, 1980) and relevant literature on congenital anomalies, cultural beliefs, parental experiences, and healthcare encounters.

The interview guide explored:

- a. parents' explanations of the origin and cause of the child's condition;
- b. cultural, familial, and spiritual explanations shared by relatives or community members;
- c. emotional responses associated with the diagnosis and perceived causation;
- d. sources of information concerning congenital anomalies;
- e. experiences with nurses, physicians, and other healthcare professionals;
- f. healthcare-seeking decisions; and
- g. experiences of combining or negotiating traditional, spiritual, and biomedical practices.

Interviews lasted approximately 45–75 minutes. With participants' permission, interviews were audio-recorded and transcribed verbatim. Field notes were maintained to document contextual observations and relevant nonverbal or situational information (Phillippi & Lauderdale, 2018).

Because the study involved culturally specific terms, expressions such as *lihi*, *pagdadahi*, *kaloob*, *usog*, and other locally meaningful concepts were retained where appropriate during transcription and analysis. When quotations were translated from Filipino or Taglish into English for presentation, the translation should be understood as an analytic representation of the participant's original account.

Data Analysis

Data were analyzed using Braun and Clarke's reflexive thematic analysis (Braun & Clarke, 2006, 2019).

The analysis involved six interconnected phases:

1. **Familiarization with the data.** The researchers repeatedly read interview transcripts and field notes to develop familiarity with participants' accounts.
2. **Generating initial codes.** Segments relevant to causality, cultural beliefs, emotional experiences, coping, healthcare-seeking, and healthcare interactions were coded.
3. **Constructing initial themes.** Related codes were examined for broader patterns concerning explanatory models and parental experiences.
4. **Reviewing themes.** Candidate themes were examined against the dataset to assess their coherence and relationship to the research objectives.
5. **Defining and naming themes.** Themes were refined to capture their central organizing concepts and distinctions from one another.
6. **Producing the analytic narrative.** Themes were interpreted in relation to the research questions, explanatory model framework, cultural humility, nursing practice, and relevant literature.

Reflexive thematic analysis was treated as an interpretive process rather than as a procedure for establishing objective intercoder agreement. The researchers maintained documentation of analytic decisions and engaged in analytic discussions to examine alternative interpretations and potential assumptions.

Trustworthiness and Reflexivity

Trustworthiness was considered through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Credibility was supported through prolonged engagement with the interview material, repeated transcript review, attention to convergent and divergent accounts, and discussion of emerging interpretations among members of the research team. Where appropriate and feasible, participants were invited to clarify or elaborate on their accounts. Transferability was supported by providing contextual descriptions of the participants, healthcare settings, cultural concepts, and circumstances surrounding the phenomenon.

Dependability was supported through documentation of the research and analytic process, including decisions concerning coding, theme development, and interpretation.

Confirmability was supported through researcher reflexivity and documentation of analytic decisions. The researchers reflected on how their professional and cultural perspectives could influence interpretation of participants' accounts.

Ethical Considerations

The study protocol was approved by the Institutional Ethics Review Board (IERB). Written or documented verbal informed consent was obtained before participation. Pseudonyms or participant identifiers were used in reporting to protect confidentiality.

Because discussions of congenital anomalies, parental responsibility, stigma, and guilt could be emotionally difficult, participants were informed of their right to pause or discontinue the interview. Procedures were available for referral to appropriate psychosocial support services when participants demonstrated significant distress.

RESULTS

Four themes were developed from the participants' accounts:

Theme	Subthemes	Central Finding
1. Pluralistic Explanatory Models of Causality	Biomedical and hereditary explanations; culturally mediated maternal explanations; environmental and frightening experiences; spiritual interpretations	Parents incorporated multiple explanations, sometimes holding biomedical and cultural or spiritual explanations simultaneously.
2. The Psycho-Cultural Burden of Causal Attribution	Self-blame; maternal responsibility; stigma; social judgment; uncertainty	Some causal interpretations placed emotional and social burdens on parents, particularly mothers who believed that their actions contributed to the child's condition.
3. Negotiating Parallel Systems of Care	Traditional healing; biomedical treatment; spiritual practices; family influence	Some parents described moving between or combining traditional, spiritual, and biomedical sources of care.
4. Nursing Communication as a Bridge Between Cultural Meaning and Biomedical Care	Dismissive communication; culturally humble communication; accessible explanations; reduction of blame	Healthcare interactions influenced how parents interpreted their child's condition and their willingness to engage with care.

Theme 1: Pluralistic Explanatory Models of Causality

Participants did not necessarily describe congenital anomalies through a single explanatory framework. Rather, their accounts reflected pluralistic explanatory models in which biomedical information could coexist with cultural, familial, maternal, and spiritual interpretations.

Biomedical and Hereditary Explanations

Participants described receiving biomedical explanations concerning genetics, hereditary factors, maternal health, nutrition, and prenatal development. Some participants referred specifically to information obtained from physicians or other healthcare professionals.

These biomedical explanations did not necessarily replace existing cultural interpretations. Instead, parents sometimes incorporated biomedical information into an already established family narrative concerning why the anomaly occurred.

Maternal Experiences and *Lihi*

Culturally mediated explanations concerning pregnancy experiences were prominent in participants' accounts. *Lihi* or *pagdadahi* was described in relation to maternal cravings, fixations, or experiences during pregnancy. For some parents, the belief was not necessarily held as an exclusive explanation but remained emotionally salient even after receiving biomedical information.

One participant, a mother of a child with cleft palate, explained:

"The doctor explained that it happens early in pregnancy, maybe because of lack of folic acid or genetics. But my mother-in-law kept insisting it was because of my 'lihi.' When I was two months pregnant, I kept staring at a rabbit image and craving foods I couldn't get. In our province, they say if your 'lihi' isn't satisfied, or if you fixate on something unusual, it marks the baby. I know the science, but in my heart, I kept wondering if staring at that picture really shaped my baby's lip."

This account illustrates the coexistence of biomedical knowledge and culturally transmitted explanations. Importantly, the participant's statement demonstrates that knowing a biomedical explanation does not necessarily eliminate the emotional influence of a cultural explanation.

Frightening Experiences and Environmental Explanations

Participants also described pregnancy-related fear, shock, trauma, or environmental experiences as possible explanations for congenital anomalies. These interpretations demonstrate how parents may connect memorable events during pregnancy with an unexpected outcome.

Such accounts are important clinically because retrospective causal reasoning may become particularly powerful after a diagnosis. Parents may search their memories for an event that can explain why the anomaly occurred.

Divine and Spiritual Interpretations

Spiritual explanations were also present. Some parents understood the child as a *kaloob ng Diyos* or as part of a divine plan.

These interpretations did not necessarily function as biomedical causal explanations. In some accounts, spirituality appeared to provide meaning, acceptance, or emotional strength in response to a difficult diagnosis.

This distinction is important: a spiritual belief may serve as a source of meaning without necessarily functioning as a claim about biological causation.

Theme 2: The Psycho-Cultural Burden of Causal Attribution

Participants described emotional consequences when congenital anomalies were interpreted as the result of parental actions or failures during pregnancy.

Self-Blame and Maternal Responsibility

Some mothers described wondering whether something they had done, consumed, experienced, or failed to do during pregnancy had contributed to their child's condition.

Such interpretations could transform an uncertain medical event into a perceived personal failure.

One mother of a child with clubfoot described the social consequences of such beliefs:

"Every time I went outside, neighbors would whisper, 'What did she do during pregnancy?' Some said I stepped on a mound (*nuno sa punso*), or that it was 'karma' for something my family did before. Hearing that broke me. I spent months crying, blaming myself, thinking I failed as a mother before my baby was even born. The guilt was heavier than the diagnosis itself."

The account illustrates how causal explanations can move beyond the family and become a source of community-level judgment.

Social Stigma and Judgment

Participants described situations in which family members or community members interpreted congenital anomalies through culturally familiar causal narratives. In these circumstances, parents could experience stigma because the child's condition was understood as evidence of maternal wrongdoing, failure to follow pregnancy practices, or consequences of family behavior.

These accounts suggest that the burden of an explanatory model is not determined only by whether the belief is medically accurate. The social meaning attached to the belief may also affect parental well-being.

Uncertainty and the Search for Responsibility

The accounts also suggest that parents may search for causality because uncertainty itself is difficult to tolerate. When healthcare explanations are complex or incomplete, culturally available narratives may provide an understandable answer.

For nursing practice, this finding suggests that parental questions about causation should not be interpreted simply as requests for factual information. They may also represent requests for reassurance, emotional support, and clarification concerning responsibility.

Theme 3: Negotiating Parallel Systems of Care

Participants described healthcare-seeking as a process in which traditional, spiritual, familial, and biomedical resources could coexist.

Traditional Healing as Part of Meaning-Making

Some participants described consulting traditional healers, including *albularyo* or *manghihiilot*, particularly when family members believed that a supernatural or culturally mediated cause needed to be considered.

A father of a child with congenital heart disease described:

"Before we brought him to the heart center in Manila, my elders insisted we take him to an 'albularyo' in our barangay. We performed the '*tawas*' (diagnostic ritual) to ensure no spirits were offended. Once the healer told us it wasn't supernatural, we felt relieved to focus completely on the surgery. Even now, we follow the pediatric cardiologist's prescriptions, but we still keep a blessed oil from the church at his bedside."

This account illustrates that traditional and spiritual practices were not necessarily perceived by the participant as mutually exclusive with biomedical treatment.

Biomedical Treatment as Definitive Management

Participants described hospital-based management, surgery, medications, rehabilitation, and specialist care as important components of managing congenital conditions.

For some families, biomedical care became increasingly central as the child's condition required specialized diagnosis or treatment.

Spiritual Practices as Continuing Sources of Meaning

Spiritual practices could continue even when parents accepted biomedical treatment. Prayer, blessed objects, or religious interpretations could provide comfort without necessarily replacing clinical management.

This suggests that healthcare professionals should distinguish between spiritual practices that support coping and practices that may interfere with necessary treatment.

Negotiation Rather Than Simple Replacement

The accounts suggest that healthcare-seeking may be better understood as **negotiation among multiple systems of meaning and care** rather than a simple transition from traditional to biomedical care.

For nurses, this has practical implications. Asking whether families have consulted traditional or spiritual sources of care may help identify practices that could affect treatment, while maintaining a nonjudgmental communication environment.

Theme 4: Nursing Communication as a Bridge Between Cultural Meaning and Biomedical Care

Among the most nursing-relevant findings was the influence of healthcare communication on how parents understood their child's condition.

Participants described contrasting experiences of dismissive and culturally responsive communication.

Dismissive Communication

Participants described healthcare encounters in which cultural explanations were rejected abruptly or communicated in highly technical or judgmental language.

One mother of a child with spina bifida recalled:

"The first doctor just cut me off and said, 'That's foolish superstition, read the medical chart.' It made me feel stupid and ashamed. But later, a clinic nurse sat down with me. She didn't laugh at my beliefs. She said, 'It's normal in our culture to think about 'lihi' or divine tests, but medically, here is how the spine forms in the womb, and it is nobody's fault.' She held my hand and explained it in simple Tagalog. That was the exact moment I stopped blaming myself."

The significance of this account extends beyond satisfaction with communication. The participant associated the nurse's approach with a change in her interpretation of personal responsibility.

Culturally Humble Communication

Participants valued healthcare professionals who listened to their explanations before providing information. Culturally responsive communication did not mean confirming that *lihi*, supernatural causes, or other nonbiomedical explanations were biologically responsible for congenital anomalies. Rather, it involved recognizing the cultural and emotional meaning of those explanations while clearly communicating what is known medically.

Accessible Biomedical Explanation

Participants particularly valued explanations that were understandable and delivered in language appropriate to their level of comprehension.

This finding suggests that effective nursing communication involves more than providing information. Nurses may need to translate biomedical concepts into language that parents can understand while simultaneously addressing the emotional meaning attached to their questions.

Reframing Guilt

Across participants' accounts, an important function of supportive communication was the separation of **cultural meaning from personal blame**.

Parents may retain spiritual or cultural beliefs while moving away from the assumption that they caused the congenital anomaly. This distinction provides a practical direction for nursing intervention.

DISCUSSION

This study explored how Filipino parents negotiate explanations for their children's congenital anomalies and how these explanations intersect with emotional experiences, healthcare-seeking, and professional encounters. Four themes demonstrate that parents may hold multiple explanatory models simultaneously, experience emotional consequences when causality is personalized, navigate traditional and biomedical systems of care, and respond differently depending on how healthcare professionals communicate with them.

Negotiated Explanatory Models Rather Than a Binary Choice

The findings support Kleinman's (1980) proposition that illness is interpreted through culturally situated explanatory models. Participants did not consistently divide their understanding into either "scientific" or "traditional" explanations. Instead, biomedical knowledge, family narratives, maternal experiences, spirituality, and cultural beliefs could coexist.

This finding is consistent with previous Philippine research documenting culturally mediated beliefs concerning the causes of birth defects (Felipe-Dimog et al., 2022). However, the present findings extend this literature by highlighting the **process of negotiating these explanations within healthcare encounters**.

This distinction is important. Cultural explanations should not be treated simply as competing bodies of knowledge that healthcare professionals must eliminate. Some provide emotional meaning or family continuity, whereas others may produce guilt or potentially influence care-seeking in ways that require clinical attention.

Causal Attribution and the Burden of Blame

The findings indicate that causal explanations may become psychologically consequential when parents interpret them as evidence of personal responsibility. Maternal behaviors, cravings, emotional experiences, or perceived violations of pregnancy-related expectations can become retrospective explanations for an outcome that parents could not have predicted or controlled.

This burden appears particularly gendered in participants' accounts. Mothers were more directly positioned as responsible for prenatal outcomes, while cultural expectations concerning pregnancy behavior could intensify self-surveillance and retrospective guilt.

The nursing implication is significant. When a parent repeatedly asks what caused the condition, the underlying concern may not be purely informational. The question may also mean:

"Was this my fault?"

Nurses should therefore assess both the informational and emotional dimensions of causal questions.

Traditional, Spiritual, and Biomedical Care as Parallel Systems

The findings also demonstrate that traditional and biomedical care cannot necessarily be conceptualized as mutually exclusive. Some participants described traditional healing or spiritual practices before, alongside, or after biomedical treatment.

This pattern is consistent with the broader observation that Filipino health-seeking may involve interaction among biomedical, familial, spiritual, and traditional systems of care (Alip & Canoy, 2020; Jocano, 2003; Tan, 2008). The nursing response should therefore avoid assuming that use of traditional practices automatically indicates rejection of biomedical care. Instead, nurses should assess: a. what practice was used;

- b. why the family used it;
- c. whether the practice is continuing;
- d. whether it poses a safety concern;
- e. whether it delays necessary treatment; and
- f. whether it provides emotional or spiritual support.

This approach permits culturally responsive assessment without compromising patient safety.

Nursing Communication as a Therapeutic Intervention

The fourth theme provides the strongest nursing-specific contribution of the study.

Participants' accounts suggest that communication can influence not only knowledge but also emotional adjustment. Dismissive communication was associated with shame and alienation, whereas listening, accessible explanations, and explicit reassurance concerning parental responsibility were associated with reduced self-blame. This finding is consistent with principles of cultural humility. Cultural humility requires healthcare professionals to approach patients and families with openness, self-reflection, and respect rather than assuming that healthcare professionals possess the only meaningful interpretation of a patient's experience (Foronda et al., 2016, 2020). Importantly, cultural humility does not require nurses to validate unsupported biomedical claims. The nurse can simultaneously communicate:

"I understand why your family explains it this way." and:

"Based on what medicine currently knows, this is not something you caused."

This distinction may be particularly valuable in congenital anomalies, where parental guilt can become deeply embedded in the family's interpretation of the diagnosis.

A Culturally Responsive Nursing Communication Pathway

Based on the four themes, the findings support a practical communication pathway for nursing encounters:

ASK → LISTEN → ACKNOWLEDGE → CLARIFY → EXPLAIN → REFRAME → SUPPORT 1. **ASK**

Ask parents what they believe caused the child's condition.

2. LISTEN

Allow parents to describe family, cultural, spiritual, and personal explanations without immediate correction.

3. ACKNOWLEDGE

Recognize the emotional and cultural significance of the explanation without confirming an unsupported biological claim.

4. CLARIFY

Identify which parts of the explanation are associated with parental guilt, stigma, fear, or unsafe practices.

5. EXPLAIN

Provide accurate biomedical information using understandable language and culturally appropriate examples.

6. REFRAME

Explicitly separate cultural or spiritual meaning from unsupported causal responsibility.

7. SUPPORT

Connect the family with appropriate clinical, psychosocial, genetic, rehabilitation, spiritual, or community resources as needed.

This pathway translates the findings into an actionable nursing approach while maintaining the distinction between cultural respect and scientific accuracy.

IMPLICATIONS FOR NURSING PRACTICE

The findings have several implications for nursing practice.

First, nurses should incorporate brief explanatory-model assessment into family encounters involving congenital anomalies. A simple question such as:

"What do you and your family think caused your child's condition?" may reveal beliefs that are not apparent through routine assessment.

Second, nurses should assess for parental guilt and perceived responsibility. When parents believe that a behavior during pregnancy caused the anomaly, reassurance should be integrated into health education rather than provided only when distress becomes severe.

Third, nurses should assess traditional and spiritual practices without judgment. The purpose is not to determine whether a family is "traditional" or "modern," but to identify practices that may affect safety, treatment adherence, or coping.

Fourth, health education should use understandable language. The participant account describing the nurse's explanation in Tagalog demonstrates the importance of linguistic accessibility.

Finally, family-centered care should include relevant family members when appropriate. Because explanatory beliefs may be shared and reinforced by grandparents, partners, and community members, education directed only toward the mother may be insufficient.

IMPLICATIONS FOR NURSING EDUCATION AND POLICY

The findings support the integration of culturally responsive communication into undergraduate and continuing nursing education.

Nursing curricula should prepare students to:

1. assess patients' and families' explanatory models;
2. recognize culturally mediated beliefs without stereotyping;
3. differentiate cultural meaning from biomedical causation;
4. communicate evidence-based information using culturally and linguistically accessible approaches;
5. identify parental guilt and stigma;
6. assess traditional and spiritual practices for safety; and
7. engage family members in culturally responsive health education.

At the institutional level, pediatric, neonatal, maternal-child, and genetic healthcare services could incorporate an **Explanatory Model Assessment** into family education protocols.

A suggested assessment may include:

- "What do you think caused your child's condition?"
- "What have family members or other people told you about its cause?"
- "Is there anything you did during pregnancy that you are worried may have caused it?"
- "Have you consulted anyone outside the hospital about your child's condition?"
- "What would you like us to explain more clearly?"

Such questions can identify misconceptions, emotional distress, and potential care-seeking concerns early while communicating respect for the family's perspective.

LIMITATIONS

Several limitations should be considered when interpreting the findings.

First, the study involved 18 parents recruited from selected healthcare and community settings. The findings therefore represent the experiences of these participants and should not be interpreted as representative of all Filipino parents.

Second, the participants included more mothers than fathers. Consequently, the findings provide greater insight into maternal experiences than paternal perspectives.

Third, cultural beliefs concerning congenital anomalies vary across regions, ethnolinguistic communities, socioeconomic groups, and religious contexts in the Philippines. The findings should therefore not be generalized to all Filipino cultural groups.

Fourth, participants' accounts were retrospective and may have been influenced by subsequent medical information, family discussions, and experiences following diagnosis.

Finally, qualitative interpretation is influenced by researcher positioning. Although reflexive practices were incorporated into the analytic process, the researchers' professional and cultural perspectives may have influenced the interpretation of participants' accounts.

Future studies should examine these explanatory models across multiple Philippine regions and healthcare settings and should include greater representation of fathers, grandparents, and other family members.

CONCLUSION

Filipino parents may understand congenital anomalies through multiple explanatory models that include biomedical, hereditary, maternal, familial, cultural, and spiritual interpretations. These explanations are not necessarily mutually exclusive. Parents may retain cultural or spiritual narratives while simultaneously accepting biomedical explanations and treatment.

The findings indicate that the consequences of explanatory models depend partly on the meaning attached to them. When cultural explanations become personalized as evidence of maternal wrongdoing, they may contribute to guilt, stigma, and emotional distress. Conversely, spiritual and cultural narratives may provide meaning, acceptance, and emotional support.

The principal nursing implication is that culturally responsive care requires more than correcting inaccurate information. Nurses must first understand what the belief means to the family, identify whether it generates guilt or affects care-seeking, and then provide accurate information in a respectful and accessible manner.

Culturally responsive nursing therefore involves neither uncritical acceptance nor dismissive rejection of cultural beliefs. It involves listening to the explanatory model, protecting the family's dignity, correcting harmful misinformation, reducing unjustified parental blame, and supporting informed family-centered care.

RECOMMENDATIONS

Based on the findings, the following recommendations are proposed:

1. Integrate Explanatory-Model Assessment into Nursing Practice

Pediatric, neonatal, maternal-child, and genetics-related nursing encounters should include brief assessment of parents' beliefs concerning the cause and meaning of the child's condition.

2. Strengthen Culturally Humble Communication

Nursing education and clinical training should emphasize communication strategies that allow nurses to acknowledge cultural and spiritual perspectives while maintaining evidence-based practice.

3. Include Guilt and Stigma in Family Assessment

Parents should be assessed for self-blame, shame, social judgment, and perceived responsibility following a congenital anomaly diagnosis.

4. Engage Families, Not Only Individual Parents

When appropriate and with the family's consent, healthcare education should include partners, grandparents, and other influential family members who may contribute to causal interpretations or care decisions.

5. Assess Traditional and Spiritual Practices for Safety

Nurses should ask respectfully about traditional healing and spiritual practices and determine whether these practices support coping, conflict with treatment, or create potential safety concerns.

6. Develop Culturally Responsive Family Education Materials

Hospitals and nursing institutions should develop materials in Filipino and other locally appropriate languages explaining common congenital anomalies, their multifactorial causes, available treatments, and the importance of avoiding parental blame.

7. Conduct Multicenter Philippine Research

Future qualitative studies should explore regional and ethnolinguistic differences in explanatory models. Quantitative and longitudinal studies may subsequently examine associations among culturally mediated beliefs, parental guilt, healthcare trust, healthcare-seeking, and adherence to recommended care.

8. Develop and Evaluate a Nursing Communication Intervention

Future research should develop and test the **Culturally Responsive Explanatory Model Assessment and Communication approach** proposed from these findings. Such research could determine whether structured assessment and communication reduce parental guilt, improve understanding of congenital anomalies, strengthen trust in healthcare professionals, and improve engagement with recommended care.

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