Theory and action are closely connected in medical anthropology. Theory frames the way for finding pertinent meanings and making intelligent interpretations that open the door to relevant action. Kurt Lewin's maxim that there is nothing so practical as a good theory is well known. Theory is practical because it produces the questions that matter in medical anthropological research.

This book contains 37 essays and one poem. All of them address prominent issues in present-day anthropology and medical anthropology in particular. The contributions focus on people who are excluded or marginalised because of their age, their illness, their 'madness', or violent circumstances. Others are oppressed because they do not fit in the dominant societal discourse. The essays show, however, that people are not solely victims of marginalisation. They have impressive agency and resilience, often driven by their determination to remain connected with their loved ones. Although there is much pain, fear, loneliness, injustice and violence in the contributions, there is, fortunately, also hope, friendship, care, spirit and humour.

'Theory and Action' is a gift of friends to Els van Dongen who had to resign from the University of Amsterdam because of serious health problems. 'Theory and action' reflects the main concern of her life as an anthropologist.

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Essays for an anthropologist

Sjaak van der Geest & Marian Tankink
editors

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Contents

What is cultural validity and why is it ignored?

The case of Expressed Emotions research in South Asia

SUSHRUT JADHAV*

A general problem plaguing research in the field of international psychiatry is the ignorance of cultural validity. Expressed Emotions (EE) research in South Asia is a classic example of this fallacy and difficulties associated with this research have been discussed at length (Bhugra & McKenzie 2003, Hooper 2004, Jenkins & Karno 1992, Kapur 1992).

Critiques of the International Pilot Study of Schizophrenia (IPSS) (Kleinman 1987) explicated problems inherent to Euro-American taxanomies and consequent methodological flaws in designing international mental health studies. Until recently, the field was dominated by debate over universality and relativism, but has now moved on to re-visit wider cultural and political forces that shape conceptualisation, design, interpretation and collaboration of such research activities (Williams 2003). In the process, a paucity of discussion about what is cultural validity and why is it ignored, have hindered further progress.

What is cultural validity?

If the validity of an instrument refers to actually measuring what it purports to measure with reference to the truthfulness of a theory, cultural validity extends to contextualise validity within the specific community being studied. It follows that theories and instruments need to be 'grounded' within that culture, if they have to be considered valid. Grounding implies researchers do *not* begin with *a priori* notions but instead develop theoretical constructs that reflect local concerns including indigenous theories, participant voices, priorities and values. For example, if tests on cognitive

* I am grateful to Professor Ahalya Raguram, National Institute of Mental Health & Neurosciences, Bangalore, India; for her insightful comments on Expressed Emotions research in India.

capacity, in a post capitalist society, privilege speed of response whereas in a Buddhist culture that values meditative reflection, scoring on tests will have to be in opposite directions and interpreted within each culture's norms. Similarly, the hierarchy of stressful life events in one culture might need to be re-caliberated in another to reflect severity as perceived by members of that culture. Indeed locally stressful events may lead to either cross-culturally overlapping categories or generate an entirely new set of events. Studies on cross cultural aspects of body image distress might consider moving away from a focus on anatomical physical pre-occupations in European societies to instead, the value of 'grace' and 'poise' in South Asian cultures. These are superficial examples and the issues turn more complex when deploying research instruments that aim to capture local emotions and their relationship with disease categories. Consider for example, potent emotive idioms in a multi-lingual Indian setting, such as *Pyaar se chaata mara* (Hindi for 'I slapped him with love'), *Meetha daard* (Hindi for 'sweet pain'), and *Anpu* (a complex polyphonic Tamil term for a range of love related emotions). These emotions do not slot into neat categories of over-involvement, warmth, critical comments and hostility, nor can they be assessed by hour long EE rating instruments.

Validity of Expressed Emotions research in South Asia

The Expressed Emotion findings from the much quoted Chandigarh study (Leff et al. 1987) raise several issues. Although this unreplicated research is now over two decades old, this study remains to date, the sole evidence demonstrating the causal role of Express Emotions in the relapse of Schizophrenia in South Asia. Yet the implications of findings from this study are profound. They constitute received wisdom. This is chiefly achieved through the texts that are exported to most low income nations and endorsed by local mental health professionals, who seek to *comply* with the tacit demands of their western counterparts. Indeed, ethnographic research suggests that this rhetoric of 'compliance' with international governance is perpetuated and projected by local Indian clinicians onto their patients (Jain & Jadhav in press). The published Chandigarh study states that the team of researchers had initially developed concepts of Expressed Emotions in South London, operationalised their instruments and trained (read socialised) all data collaborators to ensure reliability. Not surprisingly, the study could only discuss findings with respect to problems with inter-rater reliability. Variations on inter-cultural differences that showed up as problems in inter-rater reli-

ability during the preparatory phase, were technically fixed by altering the thresholds of ratings. The consistently lower ratings achieved by one of the raters (AG, a bi-cultural psychiatrist) on the over-involvement scale was left unexplained from a cultural perspective. Similarly, for warmth and positive comments that were found to be significantly higher amongst the Chandigarh sample compared to the London findings.

Why is cultural validity ignored?

So, why did the Chandigarh study design not consider developing indigenous concepts of emotions expressed in their full range? Why were local emotions and their attending theories not mapped out and then examined for goodness of fit with professional constructs? Had this been done, the operational mode of 'measuring' emotions might not have been restricted to a long verbal interview that relied on assessing emotions expressed through a predominant visual mode, and one that was more salient in London. What about assessing the complexity of emotions in India that include: women behind a veil, lovers who have never met, the role of food in substantiating feelings, and distressing letters from a mother-in-law, etc.? (Kapur 1992).

The consequences of demonstrating that Expressed Emotions in Chandigarh was lower than London and yet predicted relapse, are twofold: 1) It gives false credence to universalising the concept of Expressed Emotions, creating a conceptual problem of "predicting without understanding" (Jenkins & Karno 1992), and stifling much needed theoretical enquiry within the discipline of cultural psychiatry; 2) Clinicians who intervene in Indian and non-European families to 'reduce' presumed 'toxic' (in an English context) emotions might be taking away the very glue ('nourishing' emotions in an Indian context) that holds a family together, and thus negatively impact on the course of the Schizophrenia.

These issues raise questions that go beyond the debate of validity to that of cultural, ethical and political concerns for both South Asians and the local UK Black population. If, as Jenkins argues, the Expressed Emotions bandwagon has turned into a "most thoroughly examined psycho-social research construct", it is indeed surprising that there is not a single study examining the role of Expressed Emotions amongst the British Black population, despite concern over the extensively re-examined nine fold high rates of schizophrenia within this ethnic group, as compared to base rates of the white population (Jarvis 1998; Littlewood 1993).

Given the infancy of the new cross-cultural psychiatry at the time of the Chandigarh study, these invaluable insights may have eluded the researchers. As the field has now moved onto more sophisticated terrain, it might be worth cautioning both researchers and clinicians to 1) re-consider the role of culture as a valid construct central to any research in the field of international mental health, and 2) to reflect before intervening in high Expressed Emotion non-European families until the discipline establishes more firm theory that is predicated upon local cultures.

Thus, it would be premature to conclude that EE intervention for Schizophrenia is effective across cultures. The reported usefulness appears to more favour academic careers of international mental health professionals than help the culture being investigated (Jadhav 2005). In this present state of affairs, clinical work to reduce Expressed Emotions is simply dangerous outside Euro-American families unless locally validated. The past decade of research in medical anthropology and cultural psychiatry has continuously argued that the discipline of psychiatry might benefit from a fuller re-examination of its own cultural premise, rather than focus on how cultural variations in constructs such as Expressed Emotions in different societies could be better explained. Considerable efforts have focussed on researching how stigma, family support, rural lifestyles, and tolerance towards the mentally unwell, might favour better prognosis for Schizophrenia in low-income nations. Clearly, a great deal of effort and money spent would be better rewarded if researchers would also address why the course and prognosis of Schizophrenia is poorer in western countries. It would also appear that a fundamental re-education of western psychiatrists is necessary in order to stem the proliferation of spurious diagnostic categories that then find their way not only into official international systems of classifications (as these can be more easily rectified) but also into the minds of international researchers in the field. In conclusion, it may be hypothesised that a new diagnostic category of *'cultural iatrogenesis"* within future nosologies may help researchers generate some awareness of the sheer scale of institutional trauma generated by deploying 'branded' (manufactured in Euro-American cultures) scales and instruments. Returning to the case of Expressed Emotions in low-income nations, the development and application of such research methods, instruments and scales appear to be not just a matter of cultural insensitivity or about category errors. These are indeed instruments of violence (Farmer 2004).

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* Abstracting local explanations of suffering to the level of a psychopathology constitutes 'cultural iatrogenesis' (Jadhav 2007).

References

Bhugra, D. & K. McKenzie
2003 Expressed emotion across cultures. *Advances in Psychiatric Treatment* 9: 342-348.

Famer, P.
2004 An anthropology of structural violence. *Current Anthropology* 45: 305-325.

Hopper, K.
2004 Interrogating the meaning of 'culture' in the WHO International Studies of Schizophrenia. In: J.H. Jenkins & R.J. Barrett (eds) *Schizophrenia, culture and subjectivity: The edge of experience*. Cambridge University Press.

Jadhav, S.
2005 How culture bound is cultural psychiatry? *International Psychiatry* 4: 6-7.
2007 Dhis and dhat: Evidence of semen retention syndrome amongst white Britons. *Anthropology & Medicine* 14: 229-239.

Jain, S. & S. Jadhav
2009 Pills that swallow policy: Clinical ethnography of a community mental health program in northern India. *Transcultural Psychiatry* (in press).

Jarvis, E.
1998 Schizophrenia in British immigrants: Recent findings, issues and implications. *Transcultural Psychiatry* 35: 39-74.

Jenkins, J.H. & M. Karno
1992 The meaning of expressed emotions: Theoretical issues raised by cross-cultural research. *American Journal of Psychiatry* 149: 9-21.

Kapur, R.L.
1992 The family and schizophrenia, priority areas for intervention research in India. *Indian Journal of Psychiatry* 34: 1, 3-7.

Kleinman, A.
1987 Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *British Journal of Psychiatry* 151: 447-454.

Leff, J. et al.
1987 Influence of relatives expressed emotions on the course of schizophrenia in Chandigarh. *British Journal of Psychiatry* 151: 166-173.

Littlewood, R.
1993 Ideology, camouflage or contingency? Racism in British psychiatry. *Transcultural Psychiatry* 30: 243-290.

Williams, C.C.
2003 Re-reading the IPSS research record. *Social Science & Medicine* 56: 501-515.