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CLINICAL ANTHROPOLOGY: APPLIED PARTICIPANT
OBSERVATION AND THE CLINICAL PSYCHOLOGY RESEARCH
PRACTITIONER MODEL

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ABSTRACT

In the field of medical anthropology, intersections between anthropology and mental health are more easily found in the work of psychotherapists and psychiatrists than clinical psychologists. Although clinical psychologists seem just as interested as other applied mental health professions in integrating "culture" into everyday practice, the experimental nature of clinical psychology, and in particular the applications of the Anglo-Saxon research-practitioner model of clinical psychology, seem to relegate ethnography to a secondary position. While other qualitative methodologies are gradually conquering a place in clinical psychology research, ethnography is still reluctantly engaged in the work of clinical psychology researchers. This article is the first of a series of explorations proposed by the author, based on "Community Psychiatry and Clinical Anthropology" (Jadhav, 2001). It proposes an idea of clinical anthropology as a particular interaction between the research-practitioner model of clinical psychology and everyday participant observation that can serve both research and practice in clinical psychology and applied medical anthropology.

KEY WORDS: participant observation, research practitioner, clinical psychology, clinical anthropology

Clinical psychology trainers and textbooks invariably talk about the scientist practitioner model as key to the values, competencies and contributions of the profession. The origins of the model are usually traced to the Boulder Conference on Graduate Education in Clinical Psychology in 1949 (Committee on Training in Clinical Psychology, 1947; Raimy, 1950; see also Benjamin and Baker, 2000). This conference developed a model of education and training rather than a model of professional practice. Simply put, it called for clinical psychologists to be trained both as scientists and as practitioners. But it gave relatively little consideration to the actual integration of science and practice in everyday clinical work (Shapiro, 2002:232).

In a piece suggestively entitled *Community Psychiatry and Clinical Anthropology*, Sushrut Jadhav, psychiatrist and medical anthropologist, uses a narrative account to compare experiences of clinical practice in London and Bangalore (Jadhav, 2001). Jadhav sets out to explore questions in the field of community psychiatry in Bangalore, India and London, UK, that puts in evidence continuities and discontinuities between professional and lay expertise. The data stem from clinical histories and interviews with peers.

The piece starts with an outpatient visit in Bangalore where Jadhav and his colleagues are on a journey to administer a depot injection to a psychotic patient. While some colleagues set off to look for the patient who had gone astray, the author stops in at the local shop. Here, Jadhav finds out that villagers have hidden the patient at

the site of the medical van. We are then transported to London, sixteen years later, where the author is working as a community psychiatrist in a deprived area of West London. While interviewing a young white-Briton man in a community setting, the patient tells Jadhav it is time for mental health professionals to tell the government what they want, rather than serving as its messenger. The patient informs Jadhav that it is jobs and financial support they need, not a psychiatric diagnosis that may jeopardize the chances of future employability even more. Bearing one particular clinical case in mind and reflecting on the diversity of the role of the clinician in Bangalore and London, his paper concludes with a set of critical questions for thinking about culturally sensitive clinical practice.

The present paper is the first of a series of explorations by the author on the intersection of medical anthropology and daily practice in clinical psychology feeding directly on the questions advanced by Jadhav around an idea of clinical anthropology (2001). Starting from one of the questions posed by the author, "What are the cultural variations in the relationship between patients and clinicians?", I will extend this question into a reflexive enquiry of how participant-observation as practiced by anthropologists, and participant-observation as described by clinical psychologists in the cognitive-behavioural therapy model, need to come together. Standard divisions must be set aside between formal research and everyday clinical practice.



Clarification of the relation between clinical psychology and culture is required at this stage. Although clinical psychologists seem just as interested in bringing “culture” into everyday clinical practice (Kazarian and Evans, 1998) intersections on medical anthropology literature and clinical psychology research seem to stem predominantly from the work of psychiatrists and psychotherapists (e.g. Davies, 2009; Krause, 1998, 2001; Jadhav, 2001, Lester, 1997, 2000; Littlewood and Dein, 2000).

In this paper, I advance several hypotheses for the current lack of integration between the two disciplines as well as some suggestions on how to move integration forward. First, I suggest that as a research practice, ethnographic-based work on medical anthropology may present a particular set of challenges for integration into mainstream clinical psychology research. Second, I suggest that standard divisions found inside clinical psychology between formal research practices and everyday clinical practice, materialised by the ever-growing pressures felt in relation with institutional ethics committees, may partially obfuscate the research component of participant observation that accompanies all forms of clinical practice. Third, by providing a brief auto-ethnographic exploration of questions stemming from my role as a clinician in a London-based Early Intervention service, herewith described as an integrating component of that practice, I suggest that participant observation as practised by anthropologists is a valid metaphor for imagining a better integration of science and practice in clinical psychology work.

MODELS, METHODOLOGIES AND TRAINING

Although qualitative methods have been expanding in psychology and the social sciences in general (e.g., Hammersley, 1992), with psychologists gradually combining ethnographic methods and cognitive theory (Woods, 2010), clinical psychologists have yet to take to ethnography as a research method *per se*. To understand why, we must look into what the distinctive features of the research-practitioner model are and how it shapes the training of clinical psychologists. To my knowledge, despite the growing expansion of qualitative methodologies in clinical psychology research and training, one cannot complete a doctoral thesis in clinical psychology by using ethnography as the method of choice. An idea of evidence-based practice dictates that clinical psychologists should operate through a set of practices that are assessed by experimental procedures such as “randomized control trials,” often taken as the gold standard of clinical research and set against less “objective” methodologies (Sharkey and Larsen, 2005).

Related mental health fields, however, such as counseling psychology and social work, tend to utilize qualitative methods more extensively than clinical psychology. A large

component of the so-called “identity” of the field of clinical psychology is that it adheres more closely to the medical model than these other mental health disciplines, so clinical psychologists and their research colleagues tend to use quantitative methods more extensively. Quantitative methodology aligns more closely with an idea of psychology equated with forms of clinical practice stemming from the medical model.

Training in the research-practitioner model may encompass (and in countries like the UK, it invariably does) a division between learning to audit –(e.g., writing up clinical case studies) and clinical research *per se*. Pre-set distinctions between auditing, research and the writing up of individual case studies are not a constitutive part of ethnography *per se* or of the training of anthropologists in general. Ethnographically, the logic of research seems to work in reverse: an ethnographic piece can set itself simultaneously to accommodate a contextual description of a service (including individual case histories) and the wider aspects of socio-cultural enquiry (e.g., Larsen, 2004, 2007a, 2007b).

Hence, difficulties of translation between the two groups, or obstacles for greater assimilation of ethnographic-based work by clinical psychologists may derive from the way the two professional classes are taught to think differently of what is encompassed in the term “research.” In the clinical psychologists’ case, such divisions are further consolidated by a distinction acquired developmentally, that is, as a function of a training that asks of the trainee clinical psychologist to show proficiency in dividing between practices of auditing, research as practice, and clinical practice as something different from both. Here, matters conflate. Even if a clinical psychologist cannot still complete a doctoral piece by using ethnography on its own (as an independent meta-method) the idea of participant observation as a specific method is a recurring motif in cognitive-behavioural therapy.

Cognitive-behavioural therapy (CBT) is the model of therapy with which clinical psychology is more often associated. Under the auspices of the evidence-based principle embodied by the research-practitioner model, CBT is what clinical psychologists are supposed to practice when working in a therapeutic capacity (Shapiro, 2002). Yet are CBT authors and anthropologists thinking similarly when evoking an idea of “participant observation”?

In a seminal text on cognitive therapy, extending the implications of the role of the cognitive therapist in applied practice, Safran and Segal openly address the role of the cognitive-therapist explicitly as a kind of “participant observer” (Safran and Segal, 1990: 80, 84, 144, 250). Only by taking the role of participant observer, we are told, “can the therapist pinpoint in greater detail the behaviours and communications that create the pull the therapist ex-





periences and explore the cognitive processes linked to the patient's interpersonal style" (*idem*: 80).

Participant observation in CBT literature, stemming from this work, seems to address a form of inquiry by which one comes to better grasp the patients' interpersonal scheme (e.g., Safran and Segal, 1990). Participant observation in anthropological literature, often taught through Spradley's seminal book (1980), has a much broader definition. It is the methodological toolkit by which anthropologists come to simultaneously engage in activities appropriate to the situation and observe the activities, people and physical aspects of the situation (Spradley, 1980:54). In so doing, participant observation in anthropology extends far beyond individual assessment of inter-personal factors to a broader assessment of the socio-cultural context of which patients and clinicians are part.

Bearing in mind the differences between the two kinds of participant-observation herewith described (which is the same as saying, the point where they conflate), I will start sketching a third question: "What kind of clinical cultures are we actively contributing to create, in new clinical models such as EIP, when the two kinds of participant-observation converge in daily practice?"

INTERVENING EARLY

Early Intervention in Psychosis is a relatively new approach within the mental health paradigm. The Early Psychosis Prevention and Intervention Centre in Melbourne (EPPIC), which opened in 1996, provided the model for many of the Early Intervention teams that came after it. EIP specialist teams focus their work around early detection and treatment of the first episode of psychosis. The primary aim is to provide sustained care to service users throughout what is called the "critical period" (the few years following the onset of psychosis) and to work with the service-user towards the establishment of a "relapse-signature" that can help prevent or minimize future relapses (Birchwood and Jackson, 1998). Duration of untreated psychosis (DUP) is at the core of the model and a substantial argument for the implementation of EIP teams stems from the recognition of the negative impacts of delay in initiating treatment for younger people affected by psychotic disorder (e.g., Yung et al., 2003).

After a referral has been accepted, service-user involvement with an EIP team generally starts with a multidisciplinary assessment of mental state, risk factors and support needs. By and large, the approach focuses on medication with atypical anaanti-psychotics and an attempt to ensure sustained therapeutic engagement by shifting the discussion away from strict diagnosis to a broader, psychosocial view of the person. In this respect the role and the skill of the case manager or care-coordinator are vital. The

second phase in working with an EIP service-user tends to focus on mood monitoring, medication concordance, individual CBT-based therapy, psycho-education for care givers and co-construction of a multidisciplinary (MDT) health care plan. Clinical psychologists often take a dual role in EIP teams working both as psychologists/therapists and case managers, generally emphasizing either of the roles according to the specific needs of a particular client.

Within the context of EIP work, working as a psychologist on a West-London based team, I frequently engaged with clients who, soon after their first contact with the service, would question me or other professionals on ideas of CBT and EIP treatment which they had obtained through internet searches. Conversations on matters of psycho-education, including printed or online information about EIP, made it clear to me that across the board of professionals we did not have the same views on how to interpret psycho-educational material available to patients, let alone how to convey this information to patients. By and large, despite the "biopsychosocial" model we are all supposed to work with, my views were that my peers' interpretation of psycho-education were excessively medicalized, inasmuch as others felt that I tended to read psycho-education too "psychologically." As the result of these observations, it made sense to develop the practice of holding joint initial assessment meetings with the care-coordinator in order to assess more comprehensively the kind of knowledge that service users were encountering, its sources and its potential effects on their appraisal of their own situation. In time, this line of enquiry became "second nature" and ran in parallel with the standardized elements of a psychological assessment of psychosis.

By the time of initial psychological assessment, service users were frequently found to have been exposed to at least three sources of information: (a) information conveyed by previous teams and previous health professionals (e.g., general practitioner), (b) information conveyed by other members of the EIP team (family worker, consultant psychiatrist, care-coordinator or case manager and support/recovery worker), (c) information researched independently by service-users, generally obtained through internet searches via one of the more popular search engines.

As the result of these developments, all of the assessments conducted within this EIP team, from the general (multi-disciplinary) to the specific (CBT), came to incorporate an element of analysis of the knowledge that the service user had internalized through various sources (including internet access, psycho-educational leaflets or through direct verbal education from other professionals).

Qualitative literature that focuses on patient interpretation of explanatory frames of psychosis is often produced retrospectively, with the patient describing what they believe or have come to believe about psychosis "with hind-





sight" (Davidson, 2003; Larsen, 2007b, 2004). In conducting a literature review, I found no resources on patient interpretation of EIP psycho-educational materials at the point of entry to an EIP team. Drawing from anthropological ideas about online ethnography (Hine, 2000), I conducted an exploratory survey of internet material. The first aim of this survey was to try to imagine, through an experiment of online participant observation, what kind of meaning-making EIP information would offer itself as, for someone new to EIP. The second aim of this survey was to make better sense of how patients and professionals were processing online EIP psycho-educational material, something that I carried on assessing in everyday clinical practice.

PSYCHOSIS ONLINE

Hence, the three online domains searched were selected through a practice criterion, as a function of the inter-cross of the three forms of participant observation so far mentioned: 1) participant observation focusing on ideas on EIP and CBT derived from initial contacts with patients; 2) participant observation focusing on observed, shared contacts between patient and other professionals; 3) participant observation on case discussions and MDT meetings. "Psychosis," "Early Intervention in Psychosis," and "Cognitive-Behavioural Therapy for Psychosis" were the three online domains selected for this survey. A total of forty-three online documents ($N=43$) covering these three domains was gathered through searches using two of the most popular internet search engines (Google and Yahoo). An initial survey of data available online indicated fewer documents available on "CBT for psychosis" than either of the other two domains, and more documents available on general CBT than CBT for psychosis. It was therefore decided to include in the investigation documents on general CBT, but only when these documents incorporated at least some reference to the application of CBT to psychosis in the text. An indexing system was employed to label data extracts. Documents were coded by identifying letter(s) and number: *P*=document on Psychosis; *EIP*=document on Early Intervention in Psychosis; *T*=document on cognitive-behavioural therapy. Numbers were applied sequentially across each data source. Data pertaining to the three main domains was divided into segments and inter-crossed with a view toward identifying common themes running across the three domains.¹

In trying to capture the common themes to this information, I tried as much as possible to look at it with the sense of familiar unfamiliarity that would characterize a patient at the point of entry with EIP. A reflexive double-hermeneutic exercise took place between practice and online exploration. Over the process, I wrote down my hy-

potheses of what the common themes were and rewrote them when identifying something in my interpretation which sounded too much like the language of an "expert," rather than the language of a patient at the point of entry in the EIP model.

The most striking theme emerging from the data was the repeated use of prevalence statistics as a major form of on-line psycho-education about psychosis. The use of statistics on prevalence of psychosis cuts across the three domains considered, yet it is particularly prevalent in web information on EIP. In EIP websites, information on prevalence generally constitutes the opening material for the psycho-education section of the website. The use of information on prevalence denotes a tension between presenting statistical facts in a way that avoids stigma (for example, addressing psychosis as a more common problem than people may think and one that cuts across different socio-economic and ethnic groups) while simultaneously validating psychosis as a "real" problem that needs special attention (i.e., raising awareness of psychosis):

Extract 1: EPPIC website/Factsheet

Psychosis is most likely to occur in young adults and is quite common. Around 3 out of every 100 young people will experience a psychotic episode. Most make a full recovery from the experience (EIP32).

Extract 2: Care services Improvement Partnership/GP guidance leaflet "Emerging Psychosis & Young People – What you need to know"

Psychosis is one of the most serious conditions that can affect a young person: suicide – 10% lifetime risk; usually within first 5 years; highest risk at first relapse. 88% end up with no job - a path to social exclusion. Its first appearance can be bewildering for an individual. As GPs we are often the first point of contact with a health professional. There is overwhelming evidence for the benefits of intervening early in the illness: suicide risk is halved; over 50% will secure a job; if caught very early, it is possible to delay or, better, prevent the onset of a disabling psychotic illness (EIP21).

Extract 3: PEPP website (Prevention and Early Intervention Program for Psychoses)

Who is at risk?

Well over 1% of the population will develop a psychotic illness sometime in their lifetime. Young people (men age 16-25 and women 16-35) are at particularly high risk. The risk is further increased with positive family history of a similar condition, and illicit drug abuse (including cannabis). An individual at risk can have the





first episode triggered by even mild use of illicit drugs, excessive alcohol use, or stress. Individuals with all levels of intelligence and from all social backgrounds can be affected by psychosis (EIP22).

Turning from web information on Psychosis and CBT towards specific EIP websites, the emphasis of the material switches to the promotion of early detection. EIP websites deliberately target the cohort between late adolescence and earlier adulthood. In trying to meet the language of this generational group, it makes use of youth-oriented slogans on the meaning of psychosis:

Extract 4: Fraser South/Early Psychosis Intervention Website

Psychosis sucks!

Pendragon's story: In my opinion psychosis sucks! Some times I even dress myself in bags in subconscious fear of my disability taking control. Right now it's hard getting through the day to day events that roll through my head. Like the 'voices' that tell me to end my life. Even ones that tell me I'm no good, are getting worse. I still control them and continue taking my meds. It does get a little better with every new thing I accomplish. Going day to day is how I survive (...). I don't like change. Change scares me. I've never figured out why. I guess it's 'cause it brings about new energy. If you don't believe in energy it's alright. It's just something that I believe helps me get along with less struggle (EIP27).

Life stories like the one above are found in most EIP service websites. Life stories generally reflect the unexpected nature of psychosis and the stigma that goes with it: a recurring motif is the story of a service-user in their twenties or early thirties who starts by noticing some subtle changes in the world around them but decides to keep a secret of it until symptoms become too difficult to hide. Life stories work as a way of introducing awareness of early warning signs and overcoming feelings of shame and stigma that surround asking for specialized help. Hence, whereas general web information on psychosis tends to focus on symptoms at its critical stage, EIP web-information shifts the focus from symptoms to early signs:

Extract 5: PEPP Website/psycho-educational leaflet

Prodromal symptoms may include: depression and anxiety, suspiciousness, sleep disturbances, decline in functioning at school or work, poor attention and concentration, unusual perceptions, unusual beliefs and general peculiarities in behaviour, loss of energy and motivation, difficulties in thinking, social withdrawal and loss of interest (EIP 21).

Extract 6: Rethink Website/Early Intervention

The early warning signs of psychosis are vague and

sometimes hardly noticeable. There may be changes in the way people describe their feelings, thoughts and perceptions (EIP17).

Extract 7: EPPIC website/Factsheet 1

The early signs may be vague and hardly noticeable. There may be changes in the way some people describe their feelings, thoughts and perceptions, which may be come more difficult over time (EIP32).

Of all the categories that underlie the model of psychosis offered on the internet, the "prodrome" (the first phase of a psychotic episode) remains the least explicit. On the one hand, most documents emphasize the importance of early detection and rate the duration of untreated psychosis (DUP) as one of the major contributory factors to minimising the long-term impact of psychosis, hence the importance of detection in the "prodromal" phase. On the other hand, material available on-line also alludes to the onset of the prodrome as hardly noticeable by service-users and closest relatives. In the final analysis, the overall message for service-users and care givers seems to be to: a) acknowledge something which, except in rare and dramatic cases, manifests itself in subtle ways and b) acknowledge something that, however subtle at the start, can become extremely hard to recover from if left untreated.

Another identified theme was the continuity and interchangeability of roles within an EIP team. For example, the role of the clinical psychologist and the role of the care-coordinator (sometimes called case manager) are presented as interchangeable insofar as the care-coordinator is typically portrayed as offering one-to-one "counselling" and the EIP clinical psychologist serving as the case manager. The blurring of these two roles is also extended to beliefs about how outcomes are achieved. Whereas both "EIP" and "CBT" data sources were found to make use of service-users' life stories to explain and define successful outcomes, "EIP" presented successful outcomes as part of an integrated package of care where what is therapeutic is not found in any discrete piece of intervention at a certain point in time (e.g., psychological therapy during the critical period), but is found in the multidisciplinary strength of multiple interventions combined:

Extract 8, EPPIC website, Early Psychosis e-News 23

Steve was in the early stage of recovery when he was referred to the ORYGEN Group Program by his case manager. He was experiencing derogatory auditory hallucinations for a major part of each day. The voices had interfered with his concentration at university and in relationships to the extent that he had deferred his final semester of study, and was spending most of each day





alone in his bedroom. The computer games he had previously spent a lot of his spare time playing were now too upsetting for him, because he had distressing ideas of reference to them.

Steve and I met to discuss the group program. The case manager and I had previously discussed groups as a way to support Steve to maintain day structure and social contact in a supportive environment, as he continued to experience positive symptoms. Steve presented as anxious and overwhelmed, and reported that he didn't want to come to groups, because people there would be unwell and that would make him uncomfortable. We agreed to revisit the idea of group attendance if he changed his mind (EIP 34).

Steve's story continues over another two pages. We are told that in the sequence of contacts with the case manager, Steve eventually joins a music group with other service-users. Within the EIP team, Steve received other interventions described as "medication, psycho-education, supportive psychotherapy and behavioural skills training." As a consequence, it is reported that Steve's auditory hallucinations decreased. We are informed that Steve and his case manager worked on breathing techniques and as a consequence, his social anxiety in the group also decreased. In time, Steve started to attend other groups. Throughout Steve's narrative of recovery, there is no mention at all of any particular form of psychological therapy (CBT or other) or psychological intervention provided by a clinical psychologist or another CBT trained professional. The outcome is finally described by a social worker involved in the case as a result of the multiple interventions combined and of the systemic liaison among the different professionals involved:

Extract 9, EPPIC website, Early Psychosis e-News 23

- Key factors that facilitated Steve's recovery included:
- Setting clear goals for group participation;
- Flexibility of the group program to provide groups which catered to his strengths as well as supporting him through new challenges;
- All group workers being aware of Steve's goals;
- Regular liaison between group workers about his progress;
- Regular liaison between his case manager and group program keyworker;
- Case manager integration of knowledge about group participation into case management sessions;
- Steve's own recognition that group attendance would be a valuable tool for him in his recovery (EIP 34).

From the point of view of the potential service-user trying to learn about therapeutic approaches to psychosis such as EIP or specific psychological therapies, the informa-

tion gathered leaves a gap in terms of the relationship between EIP and CBT. Web information on CBT is generally around "psychopathologies" with a focus on depression or anxiety. When psychosis is mentioned as an object of CBT treatment, is it generally afforded less detail and space than anxiety-based or depression-based disorders. When EIP web information mentions therapy, CBT for psychosis as a distinctive approach within therapy is hardly mentioned. In the few documents encountered on specific CBT for psychosis, the EIP approach is rarely mentioned while CBT is presented as an intervention in its own right with no immediate liaisons between professionals described as significant in terms of possible outcomes.

Is the virtual world of EIP a world of its own that should not be taken as a direct reflection of practice or is there a strong possibility that the gaps between the information found online mirror gaps in the connection between the different disciplines, and professionals, currently working in EIP?

OBSERVING AND PARTICIPATING: A CONTRIBUTION TO THE DEFINITION OF CLINICAL ANTHROPOLOGY

EIP is not above critiques on the potential evangelical aspects of it as a model (Pelosi and Birchwood, 2003). At present, the idea of a prodromal period (a latency or dormant period preceding a full blown first episode of psychosis) that needs to be identified as soon as possible, in order to promote a better recovery, is actively practiced through online psycho-education and direct contact with EIP professionals.

In a new model of clinical practice, EIP clinical research has affirmed its strength mainly through the use of quantitative randomized control trials, while still falling short in various forms of qualitative research. This makes the purposeful conflation of two forms of participant observation operating simultaneously (one focusing on the patient, one focusing on the larger clinical model of which patient and clinician are part) all the more necessary in daily clinical practice. Genuine ethnographic work focusing on the understanding of EIP online psycho-education, for patients at the point of entry in an EIP team, is absolutely germane at this point. Online information is abundantly "out there", shaping the realities we encounter in "offline" clinical practice, and being shaped by it in return. To circumvent this element is to circumvent the question of "what kind of variable are we" in the set of variables played between patient and professional in a model of intervention actively creating the realities it sets out to identify. I believe that the tension between identifying realities considered psycho-pathological and contributing to create psycho-pathological realities by disseminating further information on psychosis, cannot be resolved. Yet the tension can be made clearer if participant





observation as practiced by anthropologists is better integrated as a component of clinical psychology practice and research.

Further integration can be rendered systematic through an idea of ethnographic action-research, (Marcus and Tacchi, 2004). As with any other form of ethnographic action-research the example here described follows a particular cycle:

1. Planning research: comparing and contrasting different notions of the person circulating across professionals in everyday EIP practice;
2. Conducting research: comparing and contrasting different readings of psycho-educational material by different professionals in an EIP team and EIP service-users; gathering online psycho-educational material; finding ways of making aspects of EIP psycho-education “familiarily unfamiliar” in order to gain insight into the patients’ perspectives;
3. Analyzing data: e.g., undertaking an exploratory survey on EIP psycho-education from the imagined patients’ viewpoints;
4. Taking action: conducting joint assessments with other professionals with a view to exploring interpretations of psycho-education fed to the patients; increasing meetings of professionals with a view of promoting reflexivity in the team around differences found in how ideas of EIP are being acted upon across professionals of different disciplines.

As far as standard clinical psychology research is concerned, beyond the obvious difference of doing away with distinctions among auditing, research, and everyday clinical practice, this form of applied participant observation genuinely works as a cycle going from step 4) to step 1) with individual cases in mind. The flipside of this approach is that it often asks the clinical psychologist to renounce the position of CBT expert he or she is often called upon to embody, and assume a position closer to a systemic or cultural consultant. It privileges meaning over authority. In all aspects, an idea of ethnographic action-research brought to daily practice mirrors the pursuit of the core competencies associated to the research-practitioner model in clinical psychology, as mentioned by Shapiro:

1. Delivering assessment and intervention procedures in accordance with protocols;
2. Accessing and integrating scientific findings to inform healthcare decisions;
3. Framing and testing hypotheses that inform health care decisions;
4. Building and maintaining effective team work with other healthcare professions that supports the delivery of scientist-practitioner contributions;

5. Supplying research-based training and support to other health professions in the delivery of psychological care;
6. Contributing to practice research and development to improve the quality and effectiveness of psychological aspects of care (Shapiro, 2002: 234).

I finish the article by going back to the narrative with which I started. London and Bangalore, as substantially different cultural contexts, inevitably ask of the clinician all sorts of changes in terms of practice. Yet neither asks of the clinician a change in the basic methodological posture of a clinician who, like Jadhav and others (including myself), is both a researcher informed by anthropology and a mental health practitioner. For this kind of clinician, participant observation, understood in the broader sense of anthropology, invariably comes to inform the small acts of everyday clinical practice -- except that there is nothing small about these acts.

If participant observation, as an ongoing assessment of a larger context intermarrying practice, should be seen as lesser a form of research is a moot point. It may just help to close some of the gaps of the clinical psychology research-practitioner model as an idea that, in the words of Shapiro himself, “gave relatively little consideration to the actual integration of science and practice in everyday clinical work” (Shapiro, 2002:232). Further explorations will extend the critical questions advanced by Jadhav (2001) around an idea of clinical anthropology as a meeting point between medical anthropology and ideas stemming from the clinical psychology research-practitioner model.

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NOTE

¹To facilitate the presentation of results, Early Intervention in Psychosis material is fully referenced in the text rather than in “References Cited.”

REFERENCES CITED

- Benjamin, Ludy T. and David Baker, Jr.
2000 “The Affirmation of the Scientist-Practitioner: A Look Back at Boulder.” *American Psychologist* 55:241-247.
- Birchwood, Max, P. Todd, and C. Jackson
1998 “Early Intervention in Psychosis: The Critical Period Hypothesis.” *British Journal of Psychiatry* 172, Supple. 33:53-59.
- Committee on Training in Clinical Psychology
1947 “Recommended Graduate Training Program in Clinical Psychology.” *American Psychologist* 2:539-558.
- Davidson, Larry
2003 *Living Outside Mental Illness: Qualitative Studies of Recovery in Schizophrenia*. New York: New York University Press
- Davies, James
2009 *The Making of Psychotherapists: An Anthropological Analysis*. London: Karnac Press.



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Foth, Marcus and Jo A. Tacchi
2004 "Ethnographic Action Research Website." In *Profiles and Experiences in ICT Innovation for Poverty Reduction*. Edited by Ian Pringle and Savithri Subramanian. Pages 27-32. New Delhi: UNESCO.

Hammersley, Martin
1992 *What's Wrong with Ethnography?* London: Routledge.

Hine, Christine
2000 *Virtual Ethnography*. London: Sage.

Jadhav, Sushrut
2001 "Community Psychiatry and Clinical Anthropology." In *Cultural Psychiatry: Euro-International Perspectives*. Edited by A. Tarik Yilmaz, Mitchell G. Weiss, and Anita Riecher-Rossler. No. 169, pages 141-154. Basel: Karger.

Kazarian, Shahe S. and D.R. Evans
1998 *Cultural Clinical Psychology: Theory, Research and Practice*. Oxford: Oxford University Press.

Kirk, Joan
1998 "Cognitive-Behavioural Assessment." In *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide*. Edited by Keith Hawton, Paul M. Salkovskis, Joan Kirk, and David M. Clark. Pages 13-51. Oxford: Oxford University Press.

Krause, Inga-Britt
1998 *Therapy Across Culture*. London: Sage.

2001 *Culture and System in Family Therapy*. London: Karnac Books.

Larsen, John Aggergaard
2004 "Finding Meaning in First Episode Psychosis: Experience, Agency and the Cultural Repertoire." *Medical Anthropology Quarterly* 18(4):447-471.

2007a "Symbolic Healing of Early Psychosis: Psychoeducation and Sociocultural Processes of Recovery." *Culture, Medicine and Psychiatry* 31:283-306.

2007b "Understanding a Complex Intervention: Person-centered Ethnography in Early Psychosis." *Journal of Mental Health* 16(3):333-345.

Lester, Rebecca
1997 "The (Dis)Embodied Self in Anorexia Nervosa." *Social Science and Medicine* 44 (4):479-489.

2000 "Like a Natural Woman: Celibacy and the Embodied Self in Anorexia Nervosa." In *Celibacy, Culture, and Society: The Anthropology of Sexual Abstinence*. Edited by E.J. Sobo and S. Bell. Pages 197-213. Madison, Wisconsin: University of Wisconsin Press.

Littlewood, Roland and Simon Dein (Eds.)
2000 *Readings in Cultural Psychiatry*. Athlone: Continuum International Publishing Group.

Pelosi, J. Anthony and Max Birchwood
2003 "In Debate: Is Early Intervention for Psychosis a Waste of Valuable Resources?" *British Journal of Psychiatry* 182:196-198.

Raimy, Victor (Ed.)
1950 *Training in Clinical Psychology*. New York: Prentice Hall.

Safran, Jeremy D. and Z.V. Segal
1990. *Interpersonal Process in Cognitive Therapy*. New York: Basic Books.

Shapiro, David
2002 "Renewing the Scientist-Practitioner Model." *The Psychologist* 15(5): 232-234.

Sharkey, S. and John Aggergaard Larsen
2005 "Ethnographic Exploration: Participation and Meaning in Everyday Life." In *Qualitative Research in Health Care*. Edited by Immy Holloway. Oxford: Oxford University Press.

Spradley, James
1980 *Participant Observation*. New York: Holt, Rinehart and Winston.

Suzuki, Linda, M. Ahluwalia, J. Mattis, and C.A. Quizon
2005. "Ethnography in Counselling Psychology Research: Possibilities for Application." *Journal of Counselling Psychology* 52(2):206-214.

Woods, Ruth
2010. "A critique of the Concept of Accuracy in Social Information Processing Models of Children's Peer Relations." *Theory & Psychology* 20(5):27.

Yung, Alison R., Lisa J. Phillips, H. Pan Yuen, M. Shona Francey, C.A. McFarlane, M. Hallgreen, and Patricia D. McGarry
2003 "Psychosis Prediction: 12-month Follow-up of a High Risk ('Prodromal') Group." *Schizophrenia Research* 60(1):21-32.

