Institution: University College London

Unit of Assessment: 24 – Anthropology and Development Studies

Title of case study: Clinical Ethnography: Anthropological research influencing clinical practice in the US, Europe, Bhutan and Myanmar

1. Summary of the impact (indicative maximum 100 words)

Clinical ethnography research at UCL has made significant contributions to clinical practice and diagnosis internationally. In Europe and the USA, this has been through the provision of teaching resources and diagnostic tools, such as the inclusion of culture-bound syndromes in the Diagnostic and Statistical Manual of Mental Disorders (DSM). In Bhutan, research was instrumental in improving the country's nascent psychiatric health services and directing them towards an appreciation of local contexts whilst applying Western medical practices. In Myanmar, research led to the development of an important vulnerability assessment tool following Cyclone Nargis, which was used to develop immediately responsive identifications of where assistance should be directed.

2. Underpinning research (indicative maximum 500 words)

Clinical Ethnography, as pioneered at UCL, is a methodology that involves immersive ethnographic study of illness and clinical practices, which is then used to inform improved clinical practice, impacting and transforming patients' experiences. Clinical Ethnography deploys ethnography not simply as an anthropological method in pursuit of anthropological data but with the additional intent, and result, of improving clinical outcomes. This interdisciplinary approach thus bridges anthropology and health sciences, reaching beyond the clinic to create socially contextualised clinical understanding.

Roland Littlewood (Professor of Anthropology since 1994) established the foundations of Clinical Ethnography through a number of key research projects which have sensitised numerous clinical practitioners to questions of cultural specificity. Internationally recognised for his research on the relationship between colonialism, racism and psychiatric theory, his findings have illuminated the social shaping of illness and diagnosis[a].

Joseph Calabrese (Teaching Fellow at UCL 2008–2009; Lecturer since 2011) has used his dual training in anthropology and clinical psychology in research projects with Native Americans, at Harvard teaching hospitals, and in Bhutan to explore the relationship between culture and mental health. Calabrese (2013) described a postcolonial healing movement which was threatened with criminalisation for its ritual use of the psychoactive peyote cactus [b]. He documented healing experiences and reports by clinicians that this healing ritual was more effective against alcoholism than standard psychological approaches. While initial fieldwork for this project was conducted before joining UCL, the analysis, research synthesis and actual drafting was completed at UCL. Calabrese's research on Harvard teaching hospitals revealed that cultural differences between clinicians and patients were not as significant a barrier to care as the mismatch between patients' need for a traditional doctor/patient relationship and the realities of the impersonal, bureaucratic culture of modern medical care [c]. This fieldwork took place in 2008, with data analysis carried out whilst at UCL. Subsequent research in Bhutan, beginning 2011, investigates local understandings of mental illness and treatment by embedding as a local clinician, which allows deep participant observation of clinical cases and local practice. Findings illuminate the lives of Bhutanese psychiatric patients, the effectiveness of modern psychiatric treatments in this context, and the role of ritual healing for less severe illnesses [d].

Based on his field research in Myanmar, and on then-ongoing research for the Lancet Commission (later published as [e]), David Napier (Professor at UCL since 2007) pioneered new ethnographic methods of disaster assessment in the aftermath of Cyclone Nargis in 2008. He demonstrated that qualitative and quantitative data could be fully integrated in a disaster setting, tying individual case studies to large data sets that direct the flow of aid resources both immediately following a natural disaster, and during periods of reconstruction [f]. Subsequently, as the member with expertise in culture and health of a 2009 UCL Lancet commission on "Managing the Health Effects of Climate Change", he and his team produced a list of recommendations on (1) disease and mortality; (2) food; (3) water and sanitation; (4) shelter and human settlements; (5) extreme events; and (6)

population and migration [e].

3. References to the research (indicative maximum of six references)

[a] Littlewood, Roland and Lipsedge, Maurice. 1997. *Aliens and Alienists: Ethnic Minorities and Psychiatry.* Third revised edition. London: Routledge. Available on request. This book has been highly cited around the world and has become a central text in medical anthropology.

[b] Calabrese, Joseph D. 2013. *A Different Medicine: Postcolonial Healing in the Native American Church*. New York: Oxford University Press. Submitted to REF2.

[c] Calabrese, Joseph D. 2011. "The Culture of Medicine" as Revealed in Patients' Perspectives on their Psychiatric Treatment. In *Shattering Culture: American Medicine Responds to Cultural Diversity*. Mary-Jo DelVecchio Good, Ken Vickery, and Larry Park (eds.). New York: Russell Sage Foundation. Submitted to REF2.
This book derives from a peer-reviewed competitive grant from the Russell Sage Foundation.

[d] Calabrese, Joseph D. and Dorji, Chencho. 2013. Traditional and Modern Understandings of Mental Illness in Bhutan: Preserving the Benefits of Each to Support GNH. Submitted to *Journal of Bhutan Studies*; This paper is publically available on UCL Discovery at http://discovery.ucl.ac.uk/1411463. Also available on request.

[e] Costello, Anthony, et al. [including Napier] 2009. Managing the Health Effects of Climate Change. *The Lancet* 373 (9676), 1659–1734. DOI:10.1016/S0140-6736(09)60935-1.
The Lancet is one of the world's most influential medical journals.

[f] United Nations, Napier, D., et al. 2008. Post-Nargis Periodic Review I: A report prepared by the Tripartite Core Group (Government of Myanmar, ASEAN, and the United Nations), December. http://reliefweb.int/sites/reliefweb.int/files/resources/2A957C4524F7C335C125752400493C8D-Full_Report.pdf.

4. Details of the impact (indicative maximum 750 words)

Research at UCL Anthropology has led to significant changes in how patients are treated and led to a culture change in psychiatry and clinical practice in Europe and the United States. Perhaps the greatest systemic change as a result of this research has been through contributions to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, or the DSM-IV (American Psychiatric Association 1994). This is the hegemonic psychiatric diagnostic manual used daily by practitioners around the world, and which determines diagnosis and health insurance, particularly in the USA. Contributions to this manual have enhanced practitioners' understanding of the cultural dimensions of psychiatric disorder.

Littlewood applied findings from his long and influential career of research on the cultural shaping of mental illness in the Caribbean and elsewhere (e.g. [a]) in his role as a consultant on the DSM-IV. This, and its 2000 revision the DSM-IV-TR, were used throughout the impact period until superseded by DSM-5 in May 2013. Specifically, Littlewood co-authored the appendix describing culture-bound psychiatric syndromes and the systematic evaluation of cultural context, which represents the first major recognition of anthropological findings on cultural diversity in an edition of the DSM (Cave 2002). This appendix was carried forward in both the DSM-IV-TR and the new DSM-5, thus demonstrating its ongoing use in psychiatric diagnosis [1].

A 2005 study found that 26.2% of Americans qualify for a DSM-IV-TR diagnosis, a proportion unlikely to have changed during the impact period, which suggests the broad reach of this work [2]. DSM diagnoses are used by American clinicians to request reimbursement from insurance companies and to monitor morbidity and mortality by national agencies. Thus, understanding culture-bound syndromes and relating them to the appropriate DSM diagnoses was essential to ensure patients were diagnosed and treated correctly, their physicians were paid, and these cases were incorporated into national statistics during the impact census period [3].

The research has also been disseminated into clinical practice through training and the publication of key texts. For example, the findings from Calabrese's clinical ethnography at Harvard teaching hospitals [c] were published in a book that has influenced Swiss medical education. The book as a whole was the subject of a 2012 training symposium at the University Hospital of Basel, delivered

by the editors and attended by approximately 100 Swiss clinicians, who discussed the book's findings and interacted with authors. The relevance of this symposium to clinical practice is demonstrated by the fact that attendees received continuing medical education credits [4]. Similarly, Calabrese's monograph based on his Native American research [b] is used to train clinicians and medical researchers at Harvard Medical School [5].

Clinical ethnography adds an important perspective to clinical practice which was previously missing. The impact of the work of Littlewood and Calabrese on the clinical disciplines is apparent in citations of their work in medical journals that clinicians must read to stay current in their fields and that typically do not cite anthropology. For example, [a] has been cited in the *International Journal of Psychiatry in Clinical Practice* (Mosotho, et al. 2008), the *Journal of Marital and Family Therapy* (Dow and Woolley 2011), and the *Journal of Social Work Practice* (Gray, et al. 2010), to name a few references in journals representing three separate clinical disciplines [6].

The provision of robust psychiatric care is an essential aspect of delivering Bhutan's widely publicised efforts to define and improve Gross National Happiness (GNH). Yet a 2012 WHO report found there were only two psychiatrists serving the country's entire population of 672,000.[7] The mental health system is dramatically under-resourced and resistance to psychiatric care derives both from stigma and from traditional understandings of illness in terms of spirit possession, soul loss, or angry local deities, necessitating a culturally competent approach. Calabrese's action research has been instrumental in building a foundation for anthropologically-informed psychiatric services in Bhutan, and thus has contributed to the country's efforts to improve GNH.

Applying insights from his research on culture and mental illness [b, c], Calabrese positively impacted psychiatric services in Bhutan through the delivery of anthropologically informed training on-site daily to over a dozen psychiatric staff members in Bhutan during three annual summer field trips in 2011, 2012 and 2013 and through ethnographic description of the lives of Bhutanese people with mental illness [d].

A British Academy International Partnership Grant allowed Calabrese to bring Bhutan's Chief Psychiatrist and collaborator, Chencho Dorji, to UCL during April 2013 to meet British medical anthropologists and psychiatrists and learn about the latest developments in these fields. As a result, in April 2013, Calabrese signed a Memorandum of Academic Cooperation with the newly established University of Medical Sciences of Bhutan (UMSB) to develop curricula in Medical Anthropology/Clinical Ethnography and Mental Health for medical students and allied health professionals in Bhutan [8]. Training began in July 2013, with presentations delivered by Calabrese to approximately 30 staff of the new university, including the directors of constituent institutes such as the Royal Institute of Health Sciences. Calabrese was appointed Visiting Lecturer, not only to create programmes in Medical Anthropology, but also to help orient the university toward a more biopsychosocial and humanistic orientation generally. Calabrese is thus integrating these fields firmly into Bhutan's nascent system of medical education.

An important aspect of Calabrese's work is direct public engagement and use of local media to inform the Bhutanese population about the nature of severe mental illnesses and what forms of treatment may help. Calabrese has been interviewed on Bhutanese radio, for example, an interview on 6 August 2012 on Radio Valley 99.9, the country's second private radio station which covers the capital Thimphu [9]. He was also interviewed by Bhutanese newspapers and has given public lectures at the National Referral Hospital and the Centre for Bhutan Studies to groups that included traditional and modern doctors and their students, hospital staff, and Bhutanese scholars. Calabrese has also networked with Bhutanese political and educational leaders around issues of mental illness.

When it hit the impoverished coastal areas of Myanmar in 2008, Cyclone Nargis killed 150,000 and left up to one million homeless. Thanks to David Napier's research for his *Lancet* article (which, though published later, informed his Nargis work) and prior field research in Myanmar, he was contracted to create the first fully integrated qualitative-quantitative method for assessing vulnerability in a disaster rapid-assessment tool, and to train 18 Burmese to carry out work with the consent of the military dictatorship that had driven away most international NGOs at the time. Napier's assessment tool abandoned existing lengthy questionnaire schedules in favour of rapid identification techniques developed in earlier research and adapted to the fast-changing

circumstances immediately after the cyclone.

Drawing on his ongoing research on health effects of climatic events, Napier investigated the most efficient methods of rapid disaster assessment. The UN stated that fully integrated quantitative and qualitative vulnerability assessments had been attempted "but never in a disaster and post-disaster relief context due to the significant logistic and organisational requirements" (p. 96 in [10]). Napier's report to the UN and recommendations on the aftermath of Cyclone Nargis were based on a quantitative survey that involved over 13,000 people and a qualitative vulnerability study involving 349 in-depth interviews with survivors, which focused on health and other risks. Napier focused on vulnerable women and children and was able to develop immediately responsive identifications of where assistance should be directed by the Tripartite Core Group (comprising the Government of Myanmar, ASEAN and the UN). The technique was subsequently adopted for demonstration to other aid workers and organisations seeking to enhance the efficiency of their own interventions at the UN conference on Cyclone Nargis held in Bangkok later that year. This novel disaster assessment technique has subsequently been trialed in a number of settings.

5. Sources to corroborate the impact (indicative maximum of 10 references)

[1] Littlewood's contributions to DSM-IV (1994) and DSM-IV-TR (2000) are presented in Appendix I: Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes; copies of each are available on request. In DSM-5, his contribution is in the Appendix: Glossary of Cultural Concepts of Distress (pp. 135–143), also available on request. Cave, Susan. 2002. Classification and Diagnosis of Psychological Abnormality. Hove, East Sussex: Routledge, pages 135–143.

[2] 26.2% of American adults had at least one DSM-IV-TR disorder: Kessler, R. C., Chiu W. T., Demler O., et al. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005;62: 617–27. DOI: 10.1001/archpsyc.62.6.617.

[3] Use of DSM-5 by clinicians, insurers and national statistics (see p. 4–5): http://www.dsm5.org/Documents/IFINAL%20UPDATED%20Insurance%20Implications%20of%20DSM-5--FAQ%206-17-13.pdf.

[4] Notice of Swiss symposium for clinicians, including credit points for attendance: http://www.transkulturellepsychiatrie.de/wp-content/uploads/2012/09/FlyerSymposiumDiversity2012_Email-1.pdf.

[5] Incorporation of [b] into teaching: Good, Byron and Alastair Donald. Spring 2013. Syllabus of "Psychological Approaches to the Anthropology of Subjectivity" Harvard Medical School, Department of Global Health and Social Medicine, Spring Semester. Available on request.

[6] Dow, H. & S. Woolley. 2011. Mental health perceptions and coping strategies of Albanian immigrants and their families. *Journal of Marital and Family Therapy* 37(1): 95–108; Gray, Benjamin, et al. 2010. Patterns of exclusion of carers for people with mental health problems the perspectives of professionals. *Journal of Social Work Practice* 24(4): 475–492; Mosotho, Lehlohonolo, et al. 2008. Clinical manifestations of mental disorders among Sesotho speakers. *International Journal of Psychiatry in Clinical Practice* 12(3): 171–179. Available on request.

[7] Source documenting under-resourced psychiatric services in Bhutan: http://www.searo.who.int/publications/journals/seajph/whoseajphv1i3p339.pdf.

[8] Memorandum of Academic Cooperation to to develop curricula in medical anthropology at the University of Medical Sciences of Bhutan, available on request.

[9] Indicative examples of engagement activities in Bhutan: Interview on Radio Valley 99.9: http://www.facebook.com/rv99.9/posts/353637828047394; talk at the Centre for Bhutan Studies: http://www.first-thoughts.org/on/Bhutan+Studies/; see entry for 7 Sep 2012.

[10] United Nations, Napier, D., et al. 2008. Post-Nargis Periodic Review I: A report prepared by the Tripartite Core Group (Government Myanmar, ASEAN, and the United Nations), December. http://reliefweb.int/sites/reliefweb.int/files/resources/2A957C4524F7C335C125752400493C8D-Full_Report.pdf.