Roland Littlewood

In conversation with Rosalind Ramsay

Roland Littlewood (photograph kindly supplied by Leti Littlewood)

Professor Roland Martin Littlewood was born in 1947. He started his training at St Bartholomew's Hospital Medical School, London, where he obtained his BSc and later graduated MB, BS in 1973. Further studying at the Institute of Anthropology, University of Oxford led to a Diploma in Social Anthropology, obtained in 1979, and a DPhil in Social Anthropology, gained in 1987. He was awarded the MRCPsych in 1978. Since then his impressive career has been marked by equally impressive distinctions, such as the presidency of the Royal Anthropological Institute from 1994–1997. Having reviewed over 200 books, Professor Littlewood is himself the author of four: *Pathology and Identity: The Work of Mother Earth in Trinidad* (1993) won the Wellcome Medal For Anthropology as Applied to Medicine in 1993. He has also written innumerable scientific, theoretical and review papers and edited three books. Professor Littlewood has recently been elected Fellow of the Royal College of Psychiatrists.

Can we start by talking about the relationship between anthropology and psychiatry?

They have a fairly long relationship. At the beginning of this century, there was not much of a disciplinary distinction between psychology (and psychiatry) and anthropology: for example, W. H. R. Rivers was the first psychiatrist to receive the FRS and started the psychology laboratories at Cambridge and at University College London – but was also the founder of

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the 'genealogical' method in anthropology. A lot of early psychoanalysts were interested in social anthropology.

There was then a hiatus for about 30–40 years. When I went into social anthropology in the 1970s there were very few psychiatrists in Britain who had trained in anthropology – so when I moved from psychiatry into anthropology there was a general sense of it being not quite the sort of thing one did. I received a lot of remarks along the lines of 'why aren't you happy in psychiatry?' 'Why are you changing your profession?' and so on. I now have a joint position and I do clinical work and teach and research in social anthropology. I think the two are inherently related because many of the patterns we treat as diseases such as overdoses, agoraphobia, multiple personality disorder and eating disorders, are not strictly biomedical diseases, but rather, cultural constructions. I think we need a fundamentally different epistemology to understand these events. As doctors we tend to use a form and content model, loosely derived from Kant, a model which is reasonable for the psychoses. It makes some sense if you have a necessary and sufficient biological cause, but it doesn't make any sense when you haven't. Anthropology offers the more universalising option of actually looking at such non-psychotic patterns as being contextual near ritual practices, and how they differ from one society to another, and I think that encompasses quite a lot of our work.

Can you say how you started working in psychiatry?

My original interests were biological. I read for an intercalated degree in biochemistry working on enzyme kinetics, but it was later working in Hackney as a Lecturer at Bart's when I was pitch-forked into anthropology. My brother, who is a Byzantinist, had lent me Frazer's (1922) *The Golden Bough* in my teens which I thought was fairly silly stuff. Studying for the MRCPsych I read some social science, people like Ruth Benedict, Margaret Mead and so on – the American 'culture and personality' school – which I found interesting, but it was only when I was working with ethnic minorities in Hackney, particularly with people of West Indian origin, that I realised that I needed a perspective on 'culture' which psychiatry could not offer. I did some initial work on the epidemiology of schizophrenia among West Indians and found that a high proportion had a religious colouring to the illness. Maurice Lipsedge and I found that a high proportion also had short-lived acute psychotic reactions which were no longer specified in British psychiatry or in DSM–III (American Psychiatric Association, 1980). *Bouffée délirante* in French psychiatry was a lot more accepted; the French have argued that there was a considerable cultural component to these patterns and many Haitian and Cuban psychiatrists in the Francophone and Hispanic tradition had argued that there was an affinity between these states and the possession states which in British psychiatry were simply regarded as dissociative individual conditions devoid of any cultural meaning.

So I got interested in the cultural construction of these patterns and I suppose there is also a general tendency in one's life to move away from biological science to more historically and culturally grounded interpretative work. Maurice Lipsedge, my consultant at Bart's at the time, had studied anthropology for a year in Cambridge, and was very influential in my choice of anthropology. We contacted Ioan Lewis who was then a professor of anthropology at the London School of Economics (LSE) and proposed a joint research project. We were attracted to Lewis because he had written in his books on ecstatic religion and social anthropology with a certain sympathy for psychiatry, or at least for psychoanalysis. We applied for a joint social research project with African–Caribbean people in East London, failed to get it funded, and after I informally attended Jean La Fontaine's lectures at LSE, Lewis suggested that I apply for the 1978 Social Science Research Council (SSRC) post-doctoral conversion fellowship in social anthropology.

The fellowship generously paid my medical salary to become a student in anthropology for three years including the field work. I went to Oxford because I was quite interested in the Marxist–cum–Catholic tradition there, and became a student of Godfrey Lienhardt, one of Evans-Pritchard's pupils, and the author of the famous *Divinity and Experience* (Lienhardt, 1961). I studied anthropology for two years, took the diploma in social anthropology and did a year's preparation for a DPhil (writing my first book in fact), and the third year went off to the Caribbean where I stayed in a small fishing village on the north coast of Trinidad.

The original idea was that I was going to look at Caribbean concepts of mental illness of particular relevance to first generation migrants in Britain. In actual fact, after about six months I reckoned (incorrectly) I knew everything there was to know about the local concepts of illness in my village, and I went off and did my DPhil on a new religious movement, an Afro-centric movement a bit like Rastafari but more radical and feminist, which had established a community in the bush, a group known as the Earth People. On my return to Britain I wrote my doctorate about

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them and a book which followed called *Pathology and Identity* (Littlewood, 1993).

At the same time as doing your anthropology research had you been continuing to practise as a psychiatrist?

Not for the three years of my fellowship from the SSRC. It was great being a student again! When I had finished my initial field work, I found living in the Caribbean at the village level was very cheap so I actually stayed for longer than I had intended. I was uncertain about continuing in anthropology and I always intended to go back to psychiatry. In fact I have become rather more of an anthropologist than a doctor in recent years.

A locum job which turned into a fixed job was arranged for me at Guy's where I became a senior registrar in psychiatry. Guy's, like Bart's, was very sympathetic to what I was doing: I was given a day off a week to write up my PhD which took about five years. However, I became a little anxious because everyone said to me 'Why have you been out of psychiatry for so long and what has this work got to do with psychiatry?' I despaired for some time of actually combining the two; there was no suitable job at Guy's and a couple of years later I went off to Birmingham University where I got a senior lectureship – a straight psychiatry post.

Luckily, with the help of colleagues at University College, my current position was arranged, teaching psychiatry and social anthropology at the same time. So there was a brief moment of panic in the middle of the 1980s but this seems to have settled down and it's fairly satisfactory at the moment. I teach anthropology courses for which the anthropology department gets credit and they pay part of my salary back to psychiatry.

You have written about racism and mental illness. Can you say something about the effects of racism on people developing mental illness?

I think it is now a reasonably accepted topic, but hands were lifted in horror when Maurice and I wrote our book *Aliens and Alienists* (Littlewood & Lipsedge, 1982). Racism was then an unacceptable word in medicine. You just did not talk about it at all. I still think that racism goes a long way to explaining everyday distress and psychological difficulties among African–Caribbeans, and to some extent among Asians, in part historical, in part current practice.

The big question is still how much psychological alienation contributes towards mental illness. You can rationally make a formal analogy between alienation as a social process and the sort of 'alienation' you get in the first-rank symptoms of schizophrenia. But it is very difficult to demonstrate intermediate steps between the two, getting from the political world to the psychobiological.

However, the rates of schizophrenia among West Indians in Britain are among the highest which have ever been recorded in the world. If we look at similar groups who have had high rates of schizophrenia in the world, that is in Ireland, among Croatians on the Dalmatian Coast, among French–Canadians, among Native Americans, among Australian Aborigines and among the Maori, you can argue there are certain historical and cultural similarities between these groups. Call it 'internalised colonisation' if you want. I would suggest there may be something in the neuropsychology of language in which you have to use a dominant language but in which you yourself are objectified. You are alienated by your very process of thought; which goes together incidentally with a curious culture of humour: for these cultures are associated with a great deal of self-depreciating wit, particularly the Irish and the African–Caribbean. I think in the midst of all this there is actually something in which neuropsychology will meet sociological politics and might actually lead to some clues to the wider aetiology of schizophrenia.

I am being very imprecise here, but I believe that the answer probably lies in a Maussian neurosociological model rather than in a purely biological model. The biological conditions of life of Caribbeans are of course, essentially Western. If schizophrenia is anything to do with the Third World conditions of life – say with nutritional deficit, and obstetric disadvantages and so on, it would be shared by people in Africa – who of course do not have a high rate of schizophrenia. So it is perhaps something to do with post-colonial identity and something to do with racism, I can't be much more precise than that at the present.

What are your views about stigma and mental illness?

I see from the *Psychiatric Bulletin* that people have been asked to volunteer to work on stigmatisation for the College. I have been interested in stigma for some years, a type of social response to illness whose theoretical perspective loosely comes from the work of Erving Goffman. I am very interested in popular models of mental illness; attitudes towards illness are largely what medical anthropology is all about, that is, how people, at the everyday level, regard and conceptualise different types of sickness.

Some years ago with colleagues in South Asia, Ajita Chakraborty in Calcutta and Nalaka

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Mendes in Colombo, we devised a three language questionnaire to measure stigmatisation. We devised this questionnaire in Bengali, Singalese and English, and we have completed about 3000 interviews in India, Sri Lanka and England, and then others translated it from English into Spanish, Portuguese, French Creole and Greek, and carried out a wider study. I did some of the interviews in Sri Lanka and Trinidad. We found that the lowest stigmatisation was in Calcutta, the highest in Trinidad, which was surprising for I was largely interviewing Rastafarians and Jehovah's Witnesses in the slums of Port of Spain, disadvantaged groups who might be expected to have a more sympathetic attitude to mental illness.

The Calcutta results rather go against the common assumption in Britain that people of south Asian origin have a particularly stigmatising attitude to mental illness. I think it is poor and working class populations in capitalist countries, with an economically precarious existence, who have a more stigmatising attitude, and they might happen to be south Asian or they might happen to be White English. As you increase the level of perceived deviance, for the poorer population it is more likely that there is a threshold that is reached slowly but more severely. There is perhaps more tolerance of everyday deviance among poorer populations, but it switches over rapidly on increasing the perceived deviance to argue that they are 'quite mad' in a way which maybe is not true of richer and more powerful political groups. So the Indian figures were relatively non-stigmatising maybe because the population was so poor that they fell below the point at which economic competition becomes a powerful part in any sort of stigmatisation.

What sort of things do you think the College can do to reduce stigma?

I was very critical of the College's Defeat Depression campaign because I think it did not go about the initial stage of obtaining social knowledge about depression very effectively. Using a MORI telephone poll with the word 'depression' was not the way to go about it. I think the College (or academics in general) still know very little about popular conceptions of depression.

In relation to stigmatisation, the first thing must surely be to accumulate factual data and to have an appropriate model of stigmatisation. Am I right in saying it is economically-based, a competitive social attribute? I suspect it's not based on false knowledge or false values. Think of the recent MENCAP campaign about learning disabilities, the poster about Down's syndrome which said something like, 'you call it mongolism, the doctors call it Down's syndrome, his mates call him Dave'. That sort of humanisation of something which is otherwise objectified and seen as abstract might actually work – but I'm not sure it works independently of social conditions. I think any contact, any knowledge of anyone who is 'mentally handicapped' or mentally ill, may be for some a social demerit. Just as psychiatrists get equated with their patients by Kingsley Amis, Evelyn Waugh, P. G. Wodehouse and so on! It may be that with contact with the mentally ill your own economic potential is seen as threatened unless you're upper middle class and are comfortably off, in which case, paradoxically, you might get the reverse effect in that contact with the mentally ill means that you are so secure that you can have contact with them and you don't suffer. But for the upper working class and lower middle class in a competitive environment it may be hazardous to admit identity, knowledge or even sympathy with people who have some sort of handicap.

We know about the higher use of medication and treatment under the Mental Health Act for people from ethnic minorities as well as their lower use of psychotherapy services. Can you say something about your work increasing the availability of psychotherapy for people from ethnic minorities?

In 1982 Jafar Kareem, a psychologist of Indian origin who has since died, started Nafsiyat, the Intercultural Therapy Centre, which is based in Finsbury Park in North London. This was the first organisation to provide free or low-cost counselling and psychotherapy for minority groups. I was involved soon afterwards. Although institutions of psychotherapy and psychoanalysis do not publish their ethnic breakdown, so far as we know there are very few Black people who have access to them. In a joint meeting a few years ago with a very prestigious psychotherapy institute which I won't name, we were going to present some joint cases of intercultural work, but this institute had great difficulty finding any cases at all. I am only partially a psychotherapist myself. I did the two year part-time training at the Tavistock Clinic so I can't really answer for the United Kingdom Council for Psychotherapy and similar organisations but I think it is true that adult Black people still don't get access to psychotherapy through the health service. And of course being on the whole poorer they don't have access to private therapy. At Nafsiyat, where we run a joint MSc with University College in intercultural therapy, we offer 12 initial sessions of psychodynamic psychotherapy largely paid for by the local health authority and the local council. Most of the

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London-funded service users come from Islington, Hackney and Camden, but people also come from further afield. The problem is largely the attitude and practice of the therapists themselves.

Under the influence of Michel Foucault in the 1970s, I was very struck by American psychiatric work in the nineteenth century which was evidently racist in its suppositions of Black people not being 'evolved enough' or else 'pre-logical' or whatever. I thought this was still significant. I have now modified my opinions to some extent and think that although people like Kraepelin were obviously racist, I think it is less that racist theorising is now inherent in psychiatric theory and practice than that because psychiatry is a branch of public medicine, Black people get a worse deal, the same as they do in other health areas, the criminal justice system, education, housing and so on. In other words, a pragmatic political rather than an ideological explanation within psychiatry. Economic competition again. I think the high number of Mental Health Act sections partly reflects that, together with a certain amount of prejudice about Black people and violence. But there is something in psychotherapy that is much more about cultural difference. I think the idea of normality, of the development of the self, of autonomy, which psychoanalysis in particular offers is fundamentally Western and bourgeois. Psychotherapy to some extent has to modify its concepts, when dealing with non-European cultures which are more socially based and less ideologically individualised – in theory at least. So to some extent psychotherapists have to be prepared to adapt their practice, to say something about themselves to their patients for instance, and be able to discuss racism freely. They perhaps have to be more directive, at the same time as continuing to be interpretative.

You mention that there is a MSc with UCL and Nafsiyat. What training opportunities are there in general for psychiatrists interested in anthropology?

I think the best thing to do is probably to do things in the order I did. After you have taken the Membership Exam, take a MSc in social anthropology, and do some fieldwork if you can!

We now have a specialist MSc in medical anthropology at University College and there are similar degrees at the School of Oriental and African Studies, at Brunel University and at Keele; and courses in medical anthropology at Cambridge, Goldsmiths and Durham. And I think all these places are very sympathetic to taking doctors. A few of my junior doctors in psychiatry have taken the MSc with us and among my PhD students in social anthropology I have five who are psychiatrists.

How does your work as a social anthropologist relate to your clinical practice?

I do relatively little clinical work: apart from therapy work at Nafisayat, I work with a homeless outreach team in central London and have a small out-patient clinic. I think in terms of biological psychiatry, that is in terms of psychosis, that anthropology has affected my practice much less than I once assumed it would, but I may have gained a certain sensitivity to the patient's own description of their experiences and certainly a sensitivity to stigmatisation. When I had a ward at University College Hospital I used to run a weekly therapy group for patients which looked just at the consequences of stigmatisation: how they were going to understand and present themselves and their illness once they had left the hospital.

I think in terms of the homeless again it has not proved as exciting sociologically as I had thought. I was naive in assuming that the majority of the homeless mentally ill had become homeless through social conditions and then developed mental illness. In fact most of the people we work with seem to have developed a psychotic illness while in employment, while in married relationships and then as a consequence have become homeless, so to some extent the psychiatry is primary. On the other hand, in relation to overdoses, eating disorders, multiple personality disorder, Munchausen's syndrome, Munchausen's syndrome by proxy, general dysthymia, dysfunction in everyday life and factitious disorders, I think anthropology is fundamental. I think the most important thing clinically is to give people an opportunity to describe their experience and their needs outside a medical framework, and to find out why social and personal problems tend to get medicalised. To some extent this is very similar to psychotherapy but it's a psychotherapy with definite questions which is not based on a particular model of intrapsychic analysis but just that all people seek to make sense of and articulate their own situation in accepted cultural terms.

As well as doing your research and writing up your doctorate, you have also written books that can be read by the general public and you have done some work with the media. Could you say something about your media work?

I was lucky to be asked by a small film company, Granite, to go to Haiti to make a film about zombies. The Haitians speak a similar sort of French Creole to Trinidadians so there were

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relatively few language problems and I'd already worked on sorcery in the Caribbean. Now this was not an ethnographic film, but a popular film and great fun to do! The other researchers found most of the zombies which we eventually identified so my job was just to go and talk to the individuals in question and give them a mental state examination in Creole which I did, and to investigate the circumstances of sorcery.

The conclusions I came to were that most of the people identified as zombies in Haiti (and there were probably about a 1000 a year according to local doctors) are in fact mentally ill people or people with learning disabilities who were mistakenly identified by bereaved relatives as being a dead person returned. If, somebody dies under rather uncertain circumstances, sorcery is suspected, and about three years later some wandering mentally ill person is picked up by the family and falsely recognised as the deceased person. We did DNA tests on the group of zombies and their families and found that they weren't the people their supposed relatives maintained.

I did a similar project last year looking at the Druze in the Lebanon who have a strong tradition of reincarnation. Again we needed to do something at a fairly engaging popular level so it's not real ethnography, but we interviewed people after the recent civil war in which young children were identified as reincarnations of adults who had died. We got very horrific and graphic accounts of people killed in the war; then about two or three years later their relatives picked up some young child as their incarnation. As with zombification, there are obvious social and economic gains for those involved, and again such patterns deal with socially standardised way of coping with bereavement.

But more seriously, apart from the entertainment value of such studies, I have appeared on television on a number of occasions talking about society and mental health. I believe that psychiatry should be engaged at the level of public knowledge and we shouldn't be in too much of what is generally called the ivory tower.

You have worked in a number of different places. Looking to the future would you like to be based abroad or are you happy to carry on working and practising in London?

I am happy working here as a base because in Third World countries it would be difficult to get a job in which you are both a psychiatrist and a social anthropologist. Even in India with its large number of anthropology departments it is fairly unthinkable. Also psychiatry abroad tends to be much more biomedical; in the West there is at least some engagement with social science. I am happy teaching here in my current job and going off on the occasional field exploration.

Any other plans for the future?

Well I'm now old enough to start publishing my collected works! The first volume of papers was published by Free Associations in June last year under the title *The Butterfly and the Serpent* (Littlewood, 1998). And this year, I'm giving the Wilde Lectures in Natural Theology at Oxford, looking at how personal experience becomes externalised as religious dogma. And there are edited books on psychiatry and colonialism (with Dinesh Bhugra) and on cultural psychiatry (with Simon Dein) in press. I'm still investigating certain topics such as multiple personality disorder with a monograph on that last year for the Royal Anthropological Institute (RAI) with which I have been very involved as a member of the Council and as a past President. And also on domestic sieges which is a new pattern which Maurice Lipsedge and I picked up: men threatened with separation or divorce who kidnap their children and threaten to kill them. We wrote a paper on this subject in the *British Journal of Medical Psychology*. Lest you think my work is purely sociological I have written an evolution-based paper with Maurice Greenberg on 'genetic sexual attraction': the name given to incestuous relationships in people who have been adopted and who trace and meet up with their biological relatives later in life. There is a very high frequency of them being sexually attracted to their relatives whom of course they haven't met since very early childhood. We offer a fairly Darwinian ethological model for that. I certainly don't feel that the use of anthropology in psychiatry just means you are going for a sociological model. I think it means in many ways going for a more general but more strictly scientific model than we usually use in psychiatry which is after all primarily a practice rather than a discipline. We are clinicians rather than scientists.

Can you say something about your views on multiple personality disorder?

Multiple personality disorder is a cultural construction, which is not to say there may not be something biological going on at the same time; we know that people when they are in their different personalities have different immune responses, different susceptibilities to illness, speak different languages, have different spectacle prescriptions and so on. But that is not to say that it is a biological disease which exists in autonomy from social relations. I think you have a biological difference but a biological difference

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which is also socially and culturally specified: as with spirit possessium states.

I think multiple personality disorder with the accompanying ideas on alien abductions, satanic abuse and so on is very much a cultural ideology which comes from a rather unholy alliance between feminism, popular science fiction and the Christian right, although in recent years there has been a shift towards therapists and psychologists and away from the Christian activists.

It hasn't really arrived in Britain. There have been occasional cases, but not the epidemic found in America. At Harvard University for instance, John Mack, a professor of psychiatry, runs a clinic for those abducted by aliens. Mack works with survivors – 'experiencers' as they are called, who have been kidnapped by flying saucers and then been sexually interfered with. I think we have got too much, shall I say, common sense for such a notion of multiple personality of this sort to take on here! In America it now involves very complicated forensic issues: the person in the dock maintains that they did not commit the crime because it was the 'person' in a different personality who did it, and so on.

As I suggest in my RAI monograph (Littlewood, 1997), I think it is partly a local coalition, between feminists and Christians in the USA but it also involves an enhanced cultural idiom of multiplicity. You can argue that multiplicity is very common in the popular post-Freudian and post-Jungian self-help psychotherapies; it goes along with American consumerism and social mobility in the idea that we have many potential identities which we ought to realise and give expression to, which is after all half way to saying you 'have' multiple personality disorder. The individual is now 'pluralised'.

Are there any changes you would like to see happening in psychiatry in Britain?

I am now more of an anthropologist than a psychiatrist so I'm not sure it's for me to say. I think psychiatry as a biomedically based subject cannot change too much unless we transform it into something else. Our two poles are biology and the social sciences, perhaps we shall one day divide into laboratory scientists and something like social workers? But more seriously, I think there's a great need in research terms for younger psychiatrists to realise that the social and cultural construction of illnesses is a scientific subject. In terms of training, there's maybe too much emphasis placed on biological models of mental illness which are fairly novel and short-lived. Each generation of psychiatrists preparing for the MRCPsych Exam learns as the truth the latest biological models of psychiatry which do not last very long. Sociological and cultural models on the other hand are perhaps more relevant in that they maintain a greater longevity.

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