***Taking* a history and *researching* history: get your methodology right!**

**HoPSIG Workshop, 14 March 2018**

A worst scenario story about a psychiatrist doing history, to illustrate the importance of doing history the right way. Russell Barton was one of 96 London medical student volunteers who went to Belsen concentration camp in Germany, two weeks after its liberation in 1945, to help survivors. In 1968, he wrote about the medical students’ experiences and his understanding of it based on his time there, in an invited article in Purnell’s *History of the Second World War.* He perceived parallels between the regimes controlling Belsen and NHS psychiatric hospitals, noted similar harmful psychological consequences for those held within, and commented that the public appeared to turn a blind eye to both. His article outraged readers. Some of his interpretations of Belsen were wrong, but his experience there inspired his passion and persistence to provide humane and dignified treatment and care for patients and to improve hospital facilities. Later, Holocaust deniers cited his article.

Combining skills of a doctor and training in historical methodology can be a recipe for success. But Andrew Scull highlighted perils of doctors undertaking historical research, describing psychiatrist-historians as a ‘peculiar group of amateurs’ whose

distortions have seriously compromised the scholarly usefulness of the accounts offered - creating versions of the past that serve (in ways generally obscured from their authors) to legitimate the profession’s present-day activities; or that represent a harmless form of antiquarianism but largely fail to satisfy the elementary canons of good historiography.[[1]](#footnote-1)

In summary: get your methodology right, or it will undermine your credibility as a historian. Doctors can ridicule some self-publicising amateurs as ‘quacks’. Historians will ridicule you,

History aims to analyse and understand the *past* in its own historical context. Doctors, if untrained in historical methodology, tend to follow methods of analysing history drawn from their professional medical work.

1. clinicalhistory-taking: gathering information from the past to understand a patient’s illness in the *present*.
2. chronological scientific literature review, to justify a *future* scientific / clinical research proposal, analysing previous methodology and results etc and what we can do better.

This has Whiggish (an insult from a historian!)overtones, of incremental change upon which the clinician-scientist can make further progress. At best, this is only partly true. For a clinician, analyses of the past aim to inform existing need or future activities, whereas a historian would undertake an additional ‘history and policy’ type analysis to relate past to present.

A knowledge of modern medicine may help to empathise, understand symptoms, health and illness experiences in the past, but terminology, and the significance and meaning of behaviours, signs, symptoms and illnesses change with time.

Doctors are accustomed to being detached and objective, but usually in a scientific-reductionist way, to pin-point a defined course of action, rather than to interpret the past in its cotemporaneous context.

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1. **Contextualise your material**: what was going on, what influenced events **at the time**, how did things come about, how and why did it or did it not have an impact,
2. **Don’t interpret retrospectively**, as far as possible: time travel backwards, look around yourself in the environment in which you are exploring and criticise from within the context. e.g. on ethics, Sam Robinson wrote about his induction into a new junior hospital post in the early 1950s

Mayer-Gross was a warm ebullient pyknic with a sparkling eye. A week or two after my arrival he invited me to come to his office at nine o’clock the following morning. My colleagues warned me that this would be for my statutory dose of LSD - and so it turned out; no ifs or buts. After the colourless and tasteless drink my reactions and sensations were monitored for the next four hours by MG, Robert Klein and (I think) John Raven, Director of Psychological Research. Among the various procedures was an EEG. My peers had regaled me the previous evening with expectations of vivid visual and tactile hallucinations, pictures sliding down walls and multiple delusions. To my disappointment none of these occurred; it was for me a complete non-event.

A *medical* methodology would ask about the rights and wrongs compared to today, and would comment that we have to learn from the past to do it better.

A *historian* would ask: What was going on? Why did they do it that way? Were there alternatives? What were the GMC guidelines? Did it fit with the Nuremberg Code? Was it ethical *at the time*?

1. **Be objective.** Avoid, as far as possible your personal judgement coming in. Obviously, some of that cannot be avoided. You can *use the present to help formulate meaningful questions* which you want to ask about the past, *not to give answers* or to make direct comparisons. If you have the potential to be over *involved* check your objectivity and be alert for transference and projection and other mechanisms which could impair your objectivity.
2. **Institutional memory**. If someone says that something neverhappened in the past, and what they are doing now is completely new, they are likely to be wrong! For example, how long have psychiatrists been speaking out about accessible services and dealing with stigma and discrimination? Dr Oswald commented:

# In a crusade against mental and nervous diseases the Press can be of the greatest assistance in helping to break down the prejudice against mental hospitals, in emphasising the need there exists for the early treatment of incipient cases … The present tendency on the part of the public to make flippant remarks about sufferers from mental illnesses is cruel and heartless, and should be frowned on by all humane people.[[2]](#footnote-2)

# (see *Guardian*[[3]](#footnote-3))

Another example, is Qualitative Improvement (QI) methodology new? If something like it was tried in the past, did it succeed (or fail)? If it succeeded, why did it disappear?

1. **Avoid linear interpretations** of events, e.g. x caused y, and Whig history. Whig history puts faith in the power of human reason to reshape society for the better, regardless of past history. It proposes the inevitable progress of humankind. The emphasis on the inevitability of progress leads to the mistaken belief that the progressive sequence of events becomes ‘a line of causation’. An in-depth investigation usually reveals otherwise: e.g. progress is not just science, but staff, skills, interest and creativity, chance, priorities of funders, impact, inspiration from various role models and sources e.g. Kraepelin from Kahlbaum, and Martin Roth from Willy Mayer-Gross.

Another example: under funding of mental health services may be affected by economic factors and policy; public pressure and demand; politics and status as a voting issue; patients and families fearful of stigma or losing services who do not complain; commissioners are unwilling to prioritise it…..

1. **Different things change at different rates.** Science and technological factors might change rapidly, but do psychosocial interventions or human risky behaviours change so much or so quickly? E.g. exploitation: William Wilberforce (1759-1833) leader of anti-slavery movement 200 years ago would have work to do today with modern slavery. The **Francis Report** on North Staffs revealed similar conclusions to inquiries in 1960s and 1970s, e.g. hazards of speaking out and whistleblowing. Some human behaviours need repeated vigilance.
2. **Don’t try to explain the present directly by using the past**. If you draw parallels, keep them separate from your historical analysis. Use historical material to provoke thought not to answer questions. The context has changed.

Popular quotes may be inaccurate or wrongly attributed. Several versions of these exist:

Winston Churchill: ‘The farther back you can look, the farther forward you are likely to see.’

George Santayana, philosopher (1863–1952): ‘Those who cannot remember the past are condemned to repeat it.’

Learn about **‘history and policy’** e.g. <http://www.historyandpolicy.org/> as a way of using your historical researches in clinical or policy settings.

1. **Terminology you might come across** (or might be used in response to what you write or say). Some may be insulting, as calling someone a quack, charlatan, fraud etc in medicine.

**Historiography:**  the study of the methods of historians in developing history as an academic discipline, and by extension, any body of historical work on a particular subject.

**Ahistorical:** lacking historical perspective or context

**Unhistorical:** not in accordance with history or with historical analysis

**Counterfactual history:** sometimes referred to as virtual history, a form of historiography that attempts to answer ‘what if’ questions (‘counterfactuals’) e.g. ‘If Hitler had been assassinated then…’ Don’t write counterfactual history, but make use of it in clarifying your questioning of your sources.

1. **Be cautious about making** **retrospective diagnoses**. It is rare to have all the data. Diagnostic processes were different. Dementia praecox may have been diagnosed a century ago, but how precisely does that relate to the classification of schizophrenia today? How perfect are *our* diagnoses? We use various tests to confirm diagnoses which were unavailable in the past. We might offer suggestions, but need to be very careful justifying our interpretations of symptoms in the past. It may be easier to say what someone did not have e.g. Amy Gibbs in *Sans Everything*.

**Meaning and significance of symptoms and illnesses changes**:

e.g.

In 1913, in a random sample of 100 admissions to asylums 52 male, 48 female: 15 died in under 2 months from time of admission: raises issues of what was considered insanity and how and why people were admitted

TB and other infectious diseases: treatment, recovery death, public health measures

Homosexuality –illegal - classed as a disease by DSM until 1973, and for which therapies – aversion etc – were tried to cure people.

Suicide

Syphilis. Term used in English since the 1600s[[4]](#footnote-4)

Before anti-biotics

Before the spirochete was identified

Different significance for men and women e.g. congenital syphilis

GPI / neurosyphilis: a terminal illness before malarial therapy, and likely death in an asylum.

Hysteria a neurological condition of women – but ‘shell shock’ affected that perspective

Use of opiates? Acceptable or unacceptable?

10. **Other terminology changes**. **State *why* you are choosing your terminology, or your writing can be offensive**. An earlier official term may be abandoned but it may stay in use and acquire more stigma, e.g. **idiot, imbecile, feeble minded, lunatic** – all official terms in the early 20th century. If a politician was talking about an ‘idiot’ a century ago one cannot assume that it was pejorative as it would be today: it was official jargon, and a ‘working’ clinical label.

11. **Always cite your sources**: make a note of every reference in full, including page number (may be needed for history academic journals).

12. **Always try to confirm ‘facts’**: if there is no evidence to support or corroborate them, state that. (Wikipedia references can sometimes provide a useful lead, but don’t quote it!). In scientific writing you might try to explain a statistical ‘outlier’; in history you need to check your facts.

13. **Look critically at the built and material environment**. They represent a cross sectional image at the time of building. The purpose of the early asylums did not reflect their later development.

14. **Tell it as a story!** Write in the **active, perfect tense**. Avoid passives. Active uses fewer words and is clearer about who did what to whom.

**Further reading:**

**Allan Beveridge, ‘The history of psychiatry: personal reflections’ *J R Coll Physicians Edinb* 2014; 44:78–84** [**http://dx.doi.org/10.4997/JRCPE.2014.118**](http://dx.doi.org/10.4997/JRCPE.2014.118)

Abstract: Does an engagement with the history of psychiatry benefit the practising clinician? This paper adopts a personal perspective. It sketches the ideological conflicts which have raged in the study of the history of psychiatry in recent decades and looks at the often heated debates between historians and psychiatrists on the subject. It looks at the author’s involvement with the subject and considers how this may have influenced both clinical practice and the approach to history. The paper then considers the author’s work in the field and the interplay between historical theory and clinical practice. It concludes that studying the history of their subject can make doctors more reflective about their work.

**Christopher Sirrs,‘Historical and International Perspectives on Health, Monday 4 December 2017’: (Unpublished report)**

Historians recognise that events in the past are rarely final, but continue to animate and shape the present. Unfortunately, this insight is not shared by many policymakers who, under immediate administrative and political pressure, are often forced to make decisions shorn of this valuable context.

In recent decades the diffusion of ideas between historians and policymakers has been enhanced by networks such as History and Policy, and events such as witness seminars which bring together influential figures such as politicians and civil servants to discuss events of historical interest. However, more remains to be done to facilitate these exchanges and bring historical experience to bear on major issues of contemporary relevance.

Health is an area of public policy where historians can make significant impact. Secular changes, for example the changing patterns of disease, rising health expenditures, and ageing populations beg a long-term historical view. Pressing problems facing health policymakers, such as perennial winter health crises, budget cuts, and administrative reorganisations may appear to be ‘of the moment’, but they can bear the imprint of former policy processes that historians can uncover. The various configurations health systems take, and the principles on which they stand, are often taken for granted by members of the public and observers in the media; moreover, they are often considered sacrosanct, limiting the scope of public and academic enquiry. Historians can bring a unique perspective to health policy, addressing questions such as why health services are organised and financed the way they are; what constitutes public health, and how it is demarcated from other aspects of health care; and the role of policy actors such as international and voluntary organisations.

Working alongside other social scientists, historians can help bring public health and health systems into focus by elucidating the social, cultural, political and economic conditions that have shaped them. For example, historians can inform current policy debates by exposing the rationales behind past decisions, the problems and constraints faced by policymakers in the past, and the wider influence of other agents in the policy field. Given the centrality of path dependency to health systems, historians can highlight the future trajectories they might take by tracing their historical path.

The turnover of politicians and civil servants as part of the ordinary operation of government means that institutional memory can be lost and historical experience is likely to be absent from policy decisions. This leads each generation to ‘reinvent the wheel’. Moreover, continual government reforms may inhibit the accumulation of a shared *esprit de corps* in healthcare organisations and an understanding of their aims and purpose. Historians can thus enhance the policymaking process by being party to decisions and explaining the background to current policy debates. None of this is straightforward. In order to bring this aim into fruition, there is a need not only for a more formal mechanism to bring historians into contact with policymakers, but also for existing mechanisms, such as History and Policy, to be exploited to the full.

1. Andrew Scull, ‘Psychiatry and its historians,’ History of Psychiatry, (1991) 2: 239-250 p.239. [↑](#footnote-ref-1)
2. ‘Asylum Report for 1915’ *BJPsych* 1917, 63, 281-295 p.291 [↑](#footnote-ref-2)
3. # Sarah Marsh, ‘People with mental illnesses refused access to insurance cover’ <https://www.theguardian.com/society/2018/jan/19/people-with-mental-illnesses-refused-access-to-insurance-cover>

   [↑](#footnote-ref-3)
4. 1653, W. Harvey [*Anat. Exercitations*](javascript:void(0)) lxxii. 550  <http://www.oed.com/> [↑](#footnote-ref-4)