

Preface

I am grateful to Professor Schioldann for asking me to preface this instalment of his work on the history of the introduction of lithium into medicine and psychiatry. The best homage one can pay to a book is to show how its contribution goes beyond what the dust jacket might indicate, *i.e.* to place it at venues other than the author planned to visit.

Writing in this vein I should like to say that this is an important book on various accounts. The clinician and the historian will profit from its scholarly riches and bountiful information. One can but be surprised at the extraordinary amount of data available on such an (apparently) narrow theme. Attentive perusal shows why this is the case. It just happens that lithium, a rather unassuming metal, has been used medically for a long time, and a fascinating link can be noticed between the history of its identification and, later, between its clinical usage and Scandinavia. In this regard, no one can blame Professor Schioldann for sporting a touch of dignified pride and for reclaiming a fair portion of the story for his country of origin, Denmark.

Matters Historiographical

The book will hold the attention of those interested in the epistemology of historiography, particularly for those interested in the way in which methods of history-making determine the type and quality of the resulting historical knowledge. Professor Schioldann's book offers a good illustration of the pros and cons associated with the application of a historiographical method that combines approaches variously termed 'internalist', 'linear' and 'presentistic'.

All historical writings are guided by a historiographical style. This will determine: i) the questions to be asked; ii) the shape of the field of enquiry; iii) the documents considered relevant to the inquiry, and iv) the definition and the standards of validity and proof used to decide on what constitutes 'historical evidence'. In the context of science and medicine, 'internalist' and 'presentistic' refer to styles that want to determine 'priority' ('who said it first') on the basis of a gold standard provided by the here and now. By privileging the present, presentistic historiographies vindicate the notion of scientific progress and satisfy the intuitions that most medics entertain about the nature and evolution of their discipline. Internalist historiographies tend also to concentrate on the study of the published writings of would-be protagonists. Linear historiography is closely related to the notion of progress

and assumes that the sciences grow linearly, forming a unitary spine along which all individual discoveries are to be aligned.

INTERNALISM, PRESENTISM, AND LINEARITY COMBINED

The ideal of this hybrid approach is to map, hierarchize, and prioritize the contribution of protagonists, and to create an incremental concatenation of their discoveries. As is the case with this book, in the capable hands of a first-class clinical-historian this approach can give rise to powerful biographical accounts and to an unmatched accumulation of data pertaining to the object of study; in this case, that object is lithium.

The determination of priority culminates in this type of historiography. In this book, priority is determined by the application of incremental criteria of scientificity. It asks: a) who used Lithium first in relation to a particular (and correct) mental disorder; b) who justified this use by wielding a particular theory of the said disorder; c) who demonstrated its usefulness by means of approved evidential methodology, *e.g.* a randomized clinical trial. Presentistic historiography dictates that criteria **a** to **c** be calibrated in terms of what current psychiatry approves.

Often found associated with presentism is the desideratum that there should be only one line of progress and development. Parallel lines or programmes, each with its own criteria for success and truth, are not welcomed. In this unilinear historical series the historian wants to find one and only one rightful place for each protagonist.

A common pitfall here is that criteria **a** to **c** are often insufficient enough to determine priorities. The historian must then resort to a second evidential level constituted by non-official publications (correspondence, confessions to a friend, declarations in unguarded moments, *etc.*) that might give an idea of whether protagonists were aware of earlier discoveries and of their motivation and honesty. Recourse to subjectivity, however, soon becomes a slippery slope. How to evaluate unguarded declarations? Did a protagonist know more about the contribution of earlier protagonists than he ever officially let on? Did he pretend not to know? If thus, what was his reason for doing so? Peering over the souls of protagonists is uncomfortable and most historians soon recoil to declare that the problem must be left open to further interpretation. They do so in the hope that some day an unknown document might emerge that contains clinching information.

The fact that its truth criteria are epistemologically dependent upon an ever-moving present renders the presentistic model unstable: its process of historical evaluation soon leads to a morass. For example, the following idealized schema represents a real situation valiantly faced by Professor Schioldann.

Given that:

- a) at time one, Protagonist A did use lithium for Disease X based on the view that its aetiology was M
- b) at time two, Protagonist B did use lithium for Disease X based on view that its aetiology was N
- c) at time three, we believe that lithium works in Disease X, and that the aetiology of the latter is N,

should A or B be considered as having been the ‘first’ protagonist to have introduced lithium into therapy?

This scenario can be made even more complicated by adding:

- d) B actually knew about A’s usage but did not declare it
- e) it is not clear that A and B actually meant the same by X
- f) A and B used different methods to ascertain the usefulness of lithium

At this stage, a historian wanting to resolve the problem of ‘who did it first’ is tied into knots, particularly if he does not give up his quest of ascertaining priority.

THE CONTEXTUALIZING HISTORIOGRAPHIES

One way out of the ‘priority’ impasse is to contextualize protagonists and their work.

Contextualization is a process difficult to describe *oratio recta*. Hence, analogical devices have been introduced for this purpose. According to one proposed by Ferdinand Braudel, at a given moment in time at least three historical processes run in parallel—each offering a different type of explanation. There is a deep process of ‘long duration’ (which may have been going on for centuries), then a process of ‘medium duration’, and lastly one of ‘short duration’ which tends to be the one most commonly used. A full account of a historical event requires that it to be meaningfully related to all three processes. Such treble contextualization exorcises the question of ‘who did it first’, for it becomes clear that themes and actions, which on a superficial reading can only be explained by the ‘genius’ of the protagonist, are in fact shared by a thinking or research community and that the genius in question is but a mouthpiece. Context also does away with the bewitching belief that ‘latest is best’ because similar views are found reappearing in the ‘long duration’ process and it becomes impossible to draw a progress vector pointing towards the future.

The contextualizing process has also been described by means of a Chinese boxes analogy. It suggests the idea that the processes of medicine are contained in a larger box constituted by those of general science; and that the latter are in turn contained in a larger box constituted by social and political practices; and that these in turn are contained in the larger box of

economic structures and interests. How many of these boxes the historian should make use of depends upon the explanatory requirements of the problem in hand. In this model, once again, the conventional questions asked by internalist, presentistic and linear historians soon evaporate.

THE CONTEXTUALIZATION OF NOSOLOGICAL TERMS

In general, the contextualizing approach helps to identify the solutions to problems of continuity caused by definitional changes in medical nosology. To take an example from this book, Whytt may have stated that there is a relation between *mania* and *gout*, but since he clearly used 'mania' in its Cullean (and later Pinelian) sense it becomes clear that his claim has little to do with what Mendel or Kraepelin may have said a century later about mania. This would exonerate Whytt from participating in the priority race. The same is the case with Arnold and his usage of *mania*.

Some historians harbour the belief that this issue can be resolved by *retrospective diagnosis*. It would not do. It is, of course, possible, that when one carries out a DSM-IV re-diagnosis of Arnold's cases, there may be some that will fit into DSM-IV 'mania' but it is also the case that the rest will fit into delirium, dementia, agitated catatonia, agitated depression, *etc.* The presentistic historian may then be tempted to conclude that Arnold got it partially right. By now it should be obvious that this conclusion would not work, for it is based on the view that mental illness is a natural kind and that DSM-IV has got it right.

A contextualizing historian would analyze this problem in a different way. Because the scholarly management of the context requires the historian to find out about contemporary definitions of the mind, its components, and available forms of madness, he soon realizes that the 18th century concept of 'mania' had nothing to do with mood. At that time mania named a segment of a nosological tart that not only had a different shape, but was also sliced in a different way. The crucial issue in this regard is that in both cases, the DSM-IV and the 18th century, the slicing of the tart and its shape must be considered as equally valid for in both cases they made perfect sense in terms of the cultural frame of their historical periods. If thus, historical definitions of 'mania' cannot be concatenated in an ever-improving series of slicing methods. Indeed, there is some evidence that these methods and their results are incommensurable.

The reason for this unsurprising conclusion is that defining and slicing the tart are tasks that occur not in the empirical but in the conceptual meta-space. They are decisions taken by cultural agents in terms of social, economic and even aesthetic needs. Once these conceptual frames have been created they determine the lower-level questions that can be asked and everything else flows from them as if dictated by an ineluctable logic.

To those living within such frames there is only one 'logical' or 'reasonable' shape to the cake and only one way of slicing it. Empirical research has no problem in confirming

the said shape and method of slicing the tart. This results from the fact that the questions, the model and the empirical capture-system are already contained in the conceptual frame, and hence predetermine all empirical outcomes. In other words, if one were to transport neuro-imaging to the 18th century, it is more than likely that it would confirm the existence of the nosological categories and boundaries as entertained at the time.

THE BOOK IN HAND

For the reason stated above, this is why I believe that Schioldann's book is important. Armed with a historiography that most medics will empathize with, Professor Schioldann has tackled a hard problem and managed to advance the field. This advance not only concerns the history of lithium therapy, Schioldann providing penetrating analyses of the contributions of the Lange brothers in the late 1800s and John Cade in 1947–49, but also the history of psychopharmacology in general. He has re-mapped the field and shown that earlier maps were incomplete or inaccurate. Understandably, he has left some issues open to re-interpretation. In all fairness, it should be said that had he used a different historiographical approach he might have reached different conclusions. But that does not matter.

Professor Schioldann has been gracious and careful enough not to hurt nationalistic susceptibilities. Priority questions often raise issues of this nature. The contextualizing historian, on the other hand, has less of a problem in this regard. He does know that all nations need heroes and figures to look up to, and that the Lange brothers and Schou fulfil in Denmark the same social function as Cade does in Australia. In this regard all that the good historian can (and should) do is try and understand why it is so important for countries to have heroes, and why some official stories, however mythological they might be, cannot be changed or replaced.

Mythological stories do exist and are a challenge to historians trying to write more coherent narratives about the past. A good example is the established frame within which clinicians tend to write their historical accounts. Whether motivated by nationalistic feelings, or their own historiographical or personal preferences, earlier clinical historians created an 'official' history of psychiatry which starts with a myth of origin: Pinel 'breaking the chains' of the insane, Esquirol organizing knowledge, Griesinger 'discovering' neuropsychiatry, Baillarger bridging neurology and psychiatry and together with Falret discovering 'manic-depressive illness'. Then the account moves onto Germany where Kahlbaum, Meynert, Wernicke, and Kraepelin feature prominently. Even great historians of psychiatry like Foucault have more or less allowed psychiatry to 'start' during the same period. This mythological account has been perpetuated by the fact that current psychiatry bases her image and definition upon it; if the former were to be discarded, a great deal of the latter would become meaningless.

Why these particular protagonists were rounded up is an interesting question in itself. It seems clear that it is not because they were indisputable 'geniuses'. cursory research shows

that many of their (less well known) contemporaries were more original and creative. It is likely therefore that they were selected because they were very good at selling themselves, at managing their reputations, and using the work of other men. Once the protagonists were chosen, however, a relationship of imitation became established, in that their profiles were used as models by their successors. Being an 'important' man in psychiatry nowadays is 'being' like Kraepelin, *i.e.* having a Department, wielding power through the allocation of money and jobs, introducing new nosological categories, deciding on evaluation methods, controlling specialised journals, *etc.* However creative or original he may be, a psychiatrist who does not meet these requisites is simply not recognized as a leading figure. The dependence of current mandarins upon earlier ones is yet another explanation for the perpetuation of a mythological history of psychiatry.

The fact that Professor Schioldann's book can trigger this type of broader historiographical reflection is further evidence of its value. For this achievement he ought to be congratulated: not all books can do this.

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