**Oral History**

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Oral history has been called “the oldest and the newest form of the historical method.” [[1]](#endnote-1) It has its roots in oral tradition, the word-of-mouth transmission of memory and story that humans have practised for millennia.[[2]](#endnote-2) Such stories have long been used in the production of history. Herodotus captured first-person testimony in his account of the Persian Wars in the fifth century BCE, and the ‘griot’ praise-singers have transmitted the histories of West African peoples across centuries.[[3]](#endnote-3) However, it wasn’t until the 1930s and 940s that oral history practices were formally adopted by Western historians, defined as the deliberate collection of individual accounts of the past for the purpose of analysis and preservation. Such accounts call on a person’s memory and interpretation of the past to explore histories that would be unavailable through the traditional archival methods that have been central to the discipline since the nineteenth century. One of the earliest oral history projects, for example, sought to capture the life stories of former enslaved people in the southern states of the USA.[[4]](#endnote-4) Subsequently, oral history has been closely associated with ‘history from below’, and with local and community history, as a point of access to the voices of people who are less likely to be represented in archives, museums and other repositories of historical knowledge. For example, women, LGBTQ+ communities, people of colour and indigenous peoples, the working class, and those who have been marginalised and oppressed within dominant systems of power.

Psychiatry is one such system of power, which intersects closely with complex, overlapping indexes of oppression such as race, class, disability, gender and sexuality. Oral history has become an established technique for exploring and making visible the experiences and perspectives of those who have been silenced or erased by this system. This includes ‘patients’, survivors, family members, activists, nurses and non-medical workers. It has also been used to supplement, nuance and critique histories generated from archival sources, through the collation of interviews with psychiatrists, psychologists and policy-makers. Recently the intersection of oral history with participatory action and co-productive research methodologies has broadened its scope and potential, contributing to reparative and social justice processes. But it is not just the preserve of academic or professional historians. Many oral history projects have been generated and led by lived experience communities, with the aim of empowering people who, through remembering and interpreting their own pasts, can work to address the impact of psychiatry on their lives and produce resources for individual and collective action. These can, as Steffan Blayney explores further in his chapter in this volume, offer valuable new perspectives on the history of psychiatry.

This chapter considers the value and potential benefits of using oral history for the history of psychiatry and mental health, and discusses the challenges that this kind of research presents. Engaging directly with personal experiences, memories and stories provides unique opportunities, but questions of subjectivity, power and trauma must be acknowledged. Although oral history is a well-established technique, best practice continues to develop as notions of trust, sensitivity and the position of the researcher are foregrounded. As oral historian Michael Frisch has said “the central issues in oral history are confronted first and most deeply in practical application,” which is why this chapter discusses practical and technical as well as ethical challenges, such as interviewee recruitment, transcription and analysis.[[5]](#endnote-5) It concludes by reflecting on the therapeutic significance of oral history for people who have been marginalised within medical and psychiatric systems and by society. Its aim is to provide a theoretical, technical and ethical framework, as an entry point to a broad and diverse field.

**Defining ‘oral history’**

The term ‘oral history’ can be used to describe both a methodological process (oral history) and the records that the process creates (oral histories). The process is a type of qualitative interviewing, which involves speaking and listening to people who were involved in (or have direct knowledge of) a subject of study or interest. It has been pithily described as “the interviewing of eye-witness participants in the events of the past for the purposes of historical reconstruction”.[[6]](#endnote-6) It draws on a hybrid of archival and social science methodologies, including traditions of source analysis (history), ethnographic observation (anthropology) and semi-structured interviewing (sociology). Interviews can take a variety of forms, being more or less structured, short or long, specific or broad. However, the defining feature of an oral history interview is that interviewees are invited to remember and discuss some aspect of the past, in conversation with the interviewer. This format provides opportunities to explore a period in a person’s life, an event or a theme over time, with a focus on living memory and personal experience. For example, in the context of psychiatric history, interviews might focus on a particular type of ‘treatment’ (such as shock therapy), an institution (such as a hospital) or a life experience (such as being an LGBTQ+ young person in psychiatric care).[[7]](#endnote-7) Interviews not only describe places and events from particular points of view, but also encourage reflection on how and why things happened, what a person thought and felt, and the impact on their present and future. As a result, every oral history interview produces a unique narrative, because individuals decide how to share their stories, the language they use and the elements that are emphasised.

Oral histories are the records that are created during and after the interview, generally in the form of audio-visual recordings and transcriptions for future use. In this way the oral history process converts what would otherwise be ephemeral and transient – spoken words, memories, opinions, and thoughts – into something that can be interpreted and referenced as a historical source. They are distinct from other genres of first-person account, such as autobiography or letters, because they are produced through the interaction between the person being interviewed and the researcher. This interaction fundamentally alters the relationship between the historian and their source, as both parties are intellectually and emotionally implicated in its production.[[8]](#endnote-8) Issues of power, voice and politics are centralised. Who has authority over what is said? How does the perspective of the interviewer shape the interviewee’s narrative? How should stories be interpreted and presented? Who is the oral history for? How will it be used, not only in the first instance but thereafter? What is the relationship between the past as it was and as it is being remembered? Critical reflection on these questions is fundamental to the enterprise of oral history.

**Memory and the Past**

Memory is the central theoretical component of oral history practice. Historians have traditionally been wary of memory as a historical source in comparison to archives, material culture and the built environment.[[9]](#endnote-9) Unlike a textual document, memory is unfixed, selective, personal, sociable and in a constant state of change, defying empiricist notions of the relationship between the past ‘as it happened’ and the present. Interviews take place in the present, and reflect back on events or experiences retrospectively, generating reconstructions of the past overlaid by interpretations and feelings. An interview is a unique and dialogic encounter, as interviewees speak and elaborate on their stories in the moment, often contradicting their own earlier accounts and the accounts of others. The past changes as it is shared. If you asked the same person the same questions in a week or a year’s time, their contribution would be subtly different. It would also be changed by speaking with a different interviewer. This is because we remember in relation to others and to context. Thereafter the historian exercises their own subjectivity, implicating their own perspectives, interests and political positions in how they choose to interpret the recording and transcription of the encounter. If oral histories are archived they become available for new uses, different purposes and interpretations, which may not have been imagined by the original creators. As Geoffrey Cubitt explains:

The circumstances of oral historians’ research are … ones which repeatedly prompt them to think about memory less as a process accomplished in the past that has bequeathed products, in the form of documentary evidence, that are there to be critically scrutinized *than as a process whose outcomes are always fluid, mutable, provisional, responsive to changing conditions and to human interventions, and therefore open not just to textual scrutiny but to probing and interrogation…*[[10]](#endnote-10)

In other words, oral history cannot supply a linear, chronological and externally verifiable account of the past. While people often reference names, dates and places in interviews, they are not the primary characteristics of an oral history account. Indeed, leading oral historian Luisa Passerini suggests that oral history’s “faithfulness to reality” is the least interesting thing about it: “Memory narrates with the vivid tones of actual experience. […] what attracts me is memory’s insistence on creating a history of itself…”[[11]](#endnote-11) The value of oral history, then, is its emphasis on the subjective, intimate experiences of the individual, and how they have interpreted those experiences in broader social and cultural terms. What was life like for people of colour living in mental health institutions in the 1980s and 1990s?[[12]](#endnote-12) How did nurses and other carers feel about adults with learning disabilities before and after the emergence of community care?[[13]](#endnote-13) What was the impact of psychiatric practices on LGBTQ+ communities in the 1960s and 1970s?[[14]](#endnote-14) Questions like these, which ask people to remember with reference to their shifting perceptions and emotions, lend themselves to oral history inquiry.

**Subjectivity, Experience and Storytelling**

The postmodern turn of the late twentieth century underpins the value of oral history within histories of psychiatry. In his influential book *The Wounded Storyteller* (1995), sociologist Arthur W. Frank suggested that “The postmodern divide is crossed when people’s own stories are no longer told as secondary but have their own primary importance.”[[15]](#endnote-15) He is speaking here about the acknowledgement of personal experience, narrated by individuals about themselves, as an authentic and valid source for understanding physical and mental illness, its treatment and aftermath. His study of this “embodied knowledge” challenged interpretations based on the scientific paradigm of publications, medical records and expert opinions. Frank highlighted the epistemic inequality in the way illness had been historically constructed, arguing that technical stories about what it means, for example, to have a mental health diagnosis, discount the social, cultural, personal and emotional experience of being a ‘patient’. *The Wounded Storyteller* is representative of a shift of attention from the 1980s onwards, away from the study of the structures and systems of health care towards the subjective, multiple and personal experiences of individuals.

The same shift was evident amongst historians, who acknowledged that histories of health and medicine had obscured the varied experiences of ‘patients’ and their families in deference to the “physician-centred account.”[[16]](#endnote-16) This gave rise to histories that refocused on the perspective of the ‘mad’, including Roy Porter’s *A Social History of Madness: Stories of the Insane* (1989) and Dale Peterson’s *A Mad People’s History of Madness* (1987).[[17]](#endnote-17) Much of this research sought out and uncovered patient experience and testimony using archival methods, but oral history was also employed. Work by Diana Gittins, Jocelyn Goddard and Caroline Knowles pioneered the capture of voices of lived experience, providing both micro and macro histories of psychiatry, institutions and systems of ‘care’.[[18]](#endnote-18) These oral histories provided insights that reframed the experience of ‘madness’ and ‘treatment’, not as accumulations of historical facts but as relational concepts that could be understood and situated in new ways. Gittins, for example, described how the twentieth-century landscape and space of Severalls lunatic asylum in Essex – its wards, padded rooms and gardens – were transformed by her interviews with former patients. The “material space,” which she could see in extant photographs, maps and archives held by the North East Essex Mental Health NHS Trust, was overlaid with “another space: the space of imagination, vision, madness…” She explains: “Patients I interviewed often described their experiences of visions/delusions/epileptic fits as if they were quite distinct landscapes they inhabited…”[[19]](#endnote-19) The centring of subjective experience enabled the emergence of this alternative asylum landscape, in which the ‘patient’ rather than the doctor was the expert navigator. Archives did not (and perhaps could not) contain or delineate knowledge of this landscape – it was only available through the words of individuals who had been there. The authenticity and value of Gittins’ interviews arose not from the authorised context of production, as it would in the archive, but from an epistemological claim that what a person thinks, feels and remembers is a valid form of historical knowledge. Radical historian Raphael Samuel described this kind of knowledge as “history’s netherworld – where memory and myth intermingle, and the imaginary rubs shoulders with the real.”[[20]](#endnote-20)

As well as memory and lived experience, concepts of storytelling are central to the practice of oral history. Interviews provide rich, descriptive and exploratory narratives, which are constructed not only from recollections but from a range of social norms and established stories that help a person to understand how they fit into a bigger picture. Caroline Knowles suggests that the ways in which different narratives diverge from and converge with each other in oral history is particularly revealing in the context of psychiatry. In her work with people diagnosed with schizophrenia she describes how stories about episodic and traumatic events in the pasts reveal not only an individual’s personal reality but how their understanding of the world and themselves has been constructed in relation to narrative conventions, cultural stereotypes, collective expectations and the cultural and social systems of mental health.[[21]](#endnote-21) Alistair Thomson suggests:

In our storytelling we identify what we think we have been, who we think we are now and what we want to become. The stories that we remember will not be exact representations of our past, but will draw upon aspects of that past and mould them to fit current identities and aspirations…. Memories are ‘significant pasts’ that we compose to make a comfortable sense of our life over time, and in which past and current identities are brought more into line.[[22]](#endnote-22)

The identification of “significant pasts” through the analysis of themes and ways of thinking in interviews can help in understanding the relationship between past experiences or actions and present circumstances.

In order to navigate the challenges of memory and story, oral historians deploy analytic strategies to contextualise, historicise and interpret the interviews they collect. In her work on the psychology of working-class people in Fascist Italy Passerini explored how interviewees used pre-existing cultural forms and notions to translate their personal experiences into historical narratives. Thematic analysis of interviews revealed how people connected their own beliefs and feelings to broader events and socio-cultural expectations.[[23]](#endnote-23) Tommy Dickinson found in his work *Curing Queers* (2015), that the recollections of former mental health nurses and survivors of gay conversion therapies were in a constant process of reconfiguration as they constructed their past, present and imagined selves with reference to what they understood about the wider world. For example, nurses used stories about the absolute authority of doctors in the 1960s and 1970s, and emphasised a culture of obedience to hierarchy, in order to explain and justify how things were. Some mitigated their individual roles in administering treatments for ‘sexual deviance’ by describing moments of subversion, which they framed as stories of underground resistance. This enabled them to understand what had happened in the past in ways that aligned with the recognition of LGBTQ+ rights in the present.[[24]](#endnote-24) Kerry Davies applied similar analysis to interviews with psychiatric patients from late twentieth-century Oxfordshire. She identified three key narrative frames: stories of loss, stories of survival and self-discovery, and stories of “the self as patient.”[[25]](#endnote-25) The interaction of individual experience with these established story-forms brought together inner worlds with “the outer world of the changing experience of being ill.”[[26]](#endnote-26) As Gittins had also found, the complexity of these inner worlds was not evident in the archive of the same hospital.

**Archival Deficits**

Oral history is often conceived as filling an archival deficit. There are numerous instances where no archival traces survive, because they have been lost or destroyed, or because archives cannot be accessed. The absence of records is particularly acute for historians of the later twentieth century, where many archives (and especially patient and case records) are not widely available. They may remain in the closed custody of current medical services and administrative centres, or have been destroyed in line with records management and patient confidentiality policies. [[27]](#endnote-27) In many countries around the world data protection legislation now strictly limits access to medical and other highly sensitive information during the lifetime of the subjects.[[28]](#endnote-28) This complicates access not only to case records but to any archives which may contain references to patients or staff. In such cases lived experience can fill the gap, with oral history providing a means of documenting and studying periods, times and places that would otherwise be closed to scrutiny. In time oral histories may come to form part of an archive themselves, establishing a long-term resource for future researchers.

However, even in cases where an archive survives and is available for use, it is still unlikely to provide direct access to the experiences, feelings and perceptions of patients. The development of psychiatric medicine, institutionalism and societal prejudice has persistently marginalised and silenced psychiatric service users and survivors. Those in positions of influence, with societal claims to expertise, have controlled recordkeeping. The creation, form and preservation of documents, and access to them, has been shaped by medical practitioners and policymakers. This includes the use of genres such as asylum casebooks or case notes (explored further in Chapter [x] of this volume). Within such documents, patient experiences may be described using technical language or terminology that does not represent their own perspective or experiences.[[29]](#endnote-29) Similarly, the accounts of nurses and non-medical staff are often omitted. When records are transferred to archives and become available to historians, the point of view of the psychiatrist and the institution is the view that is projected into the future.[[30]](#endnote-30)

Leavy argues that oral history is particularly valuable in these contexts, where key historical actors are obscured or paradigmatically voiceless. [[31]](#endnote-31) Oral histories can thus provide insights that are otherwise unavailable, which can either be used on their own terms or in order to critique, contrast and supplement documentary sources. For example, they can offer creative entry points to a particular research question or problem as, for example, in Fiona Byrne’s exploration of cultures of mental health hospitals in mid twentieth-century Ireland through the eyes of the children of staff members.[[32]](#endnote-32) It can also give access to intersecting issues of gender and sexuality, which may only emerge through the lens of contemporary values and understandings: Sheena Rolph, Jan Walmsley and Dorothy Atkinson’s work with Mental Welfare Officers explores the gendered landscape of disability and mental health community care in the 1950s and 1960s.[[33]](#endnote-33)

However, oral histories need not reject the archive or other sources of historical knowledge. They are generally predicated on some other form of research, either secondary or primary, which contextualises interviews as part of a mixed methods approach. Interviewees sometimes encourage this themselves, by using their own case notes, photographs or material cultures as reference points or scaffolding for their narrative. The Memory-Identity-Rights in Records-Access (MIRRA) project (2017–2019), which examined the lifelong memory and identity needs of care-experienced adults in England, found that this relationship between lived experience and archives was critical.[[34]](#endnote-34) While a person’s recollection of their past often conflicted with what social workers, psychiatrists and foster parents had written about them, social care and mental health records nevertheless played an important role in structuring and justifying their personal narratives.

Indeed, friction with absent or inhospitable records can be productive and empowering, providing a perspective to defy or argue against. The Mental Health Recovery Archive (2012–2013) was co-created by academic Anna Sexton and a team of contributors with lived experience of mental health recovery, in response to the deficit of patient perspectives in the Wellcome Library collection in London. The archive, which is available online, is compiled of oral histories, images, art, videos, poems and other creative responses to past experiences, constructed around narratives of each person’s recovery journey.[[35]](#endnote-35) This includes Sexton’s own experience of researching mental health recovery, as a person without lived experience, but with a commitment to deeply reflective and auto-ethnographic historical practice.[[36]](#endnote-36)

**Practices, technologies and practicalities**

The first step in planning an oral history project is to reflect on whether it is an appropriate method. Taking into account the potential benefits and challenges, is it the best way to explore your research interest? Questions to be asked include: What other source materials exist? Do you have a personal, political or social agenda in pursuing oral history? How difficult will it be to interview people? What questions will you ask them? How will the interviews be collected, managed and used, in the immediate and long term? The answers to these questions, and many others, will inform ethics applications to universities, and other institutions such as hospitals or the NHS, from whom you will need permission before you begin.

Although oral history may appear expansive and intuitive, given the wide-ranging content it produces, the method requires close planning as part of time-limited projects. A clear research focus will enable the identification of potential interviewees, as well as routes for making contact with them. Some research lends itself to interviewing specific individuals (such as Gittins’ research on Severalls hospital) while other projects require a cohort that is representative of a particular experience (such as Dickinson’s oral history of LGBTQI+ experience in the 1960s and 1970s). Studies can have a significant number of interviewees, like Knowles’ work with schizophrenia survivors, while others have as few as one. An example of this is Patricia Leavy and Lauren Sardi Ross’ examination of anorexia nervosa through a single life story.[[37]](#endnote-37) In either case, recruitment may be targeted, with interview requests sent directly to identified people; or self-selecting, by advertising the opportunity to participate through newsletters, social media or word of mouth. Making initial contact with potential interviewees can be difficult, depending on pre-existing relationships and the number of people you would like to speak to. If the topic is a sensitive or highly personal one, as is often the case in mental health research, there are challenges relating to trust, privacy and the use of language. Few people will volunteer to speak to a stranger without some prior contact. It may be helpful to begin by building rapport with advocacy or support organisations, or with public activists, who are able to verify your credentials and recommend individuals to approach. For example, in the case of the MIRRA project a partnership with The Care Leavers’ Association, a care leaver-led charity, helped researchers to make contact with people with relevant experience.[[38]](#endnote-38) Organisational partners or collaborators can also provide additional support, both to interviewees and to researchers, as they will have expertise of working with clients’ issues and may be able to signpost to specialist services, such as counselling if it is required.

Communication before, during and after an interview is vital. Informed consent is a pillar of oral history practice, and almost universally required by local ethics processes for research involving people. This means that all interviewees should be fully informed about the subject of the research and what will happen to their contribution, including whether it will be preserved in the long term. They should know they are being recorded, and how you will transcribe that recording. It is good practice to give interviewees the opportunity to check and amend their contribution before you use it. They should also know that they have the right to withdraw from the research at any time, at which point records of their interview would be destroyed. Data protection legislation (e.g. the General Data Protection Regulation, or GDPR, within the EU) requires that researchers clearly state how any personal information collected will be used, handled, and managed, as well as how long it will be kept.[[39]](#endnote-39) If you are affiliated to a university or Higher Education institution they will act as the “data controller” for the interviews that you collect and use as the “data processor”, and will have guidance about how the law applies to your specific project. Finally, the language and format of the information provided should be accessible and inclusive, accounting for differences in literacy and comprehension. Sensitivity about the use of labels and medicalised terms show contributors that you understand their perspective and will be respectful of their needs and feelings.[[40]](#endnote-40)

Oral history also requires equipment, and the technical expertise to use it. Increasingly interviews can be recorded using commonly owned devices, such as mobile phones or computers. However, issues such as the sound quality of the recording, the output format, reliability and privacy are still important. Needs will differ depending on a number of factors. Will you use audio or video, and why? Who will listen to the recordings? Will they be published online, or archived? Who else has access to the equipment you are using? Whatever equipment is used it is important to know how it works and to test it beforehand, so as not to cause delays or problems during or after an interview. A failed or partial recording doesn’t only impact the research, but is also upsetting or hurtful to the interviewee who has given their time and made an emotional investment in order to contribute.

The venue in which interviews take place is also a consideration. As with many aspects of the interview process, it has a relation to power. Interviewees may be uncomfortable speaking in institutional settings, such as hospitals, universities and office buildings, particularly if they have negative associations with such spaces. In these cases, it may be most convenient to meet in a neutral public space like a library or coffee shop. A partner organisation may also be able to provide a venue. However, there are practical implications to external locations, such as background noise, and the difficulty in maintaining privacy and confidentiality. Some interviewees may feel most comfortable speaking in familiar surroundings that are local to where they live. Tommy Dickinson described his decision to interview retired nurses and former patients in their own homes, to maintain “informality” and encourage easy conversation.[[41]](#endnote-41) Yet others may prefer to speak on the phone, where they feel less observed, or to meet in an open public place like a park, which they can readily leave. Consequently, it may be necessary to be flexible and responsive to the needs and preferences of individuals. However, the safety of both interviewee and interviewer is always paramount and risk has to be carefully assessed if travelling alone to unfamiliar or isolated locations.

Interviews are different to other types of conversation, in that two strangers talk about experiences and perspectives which may be deeply personal and specific. Individuals respond to this scenario differently, depending on their personalities and circumstances. If interviewees have rehearsed their memories and opinions frequently in analogous circumstances, such as to the media or as part of advocacy work, then they may speak with confidence. Similarly, if they feel they are in a position of authority or expertise, i.e. as a medical professional speaking to a non-professional, they may share more freely. Others may not have spoken to anyone about a topic before and therefore be reticent. These circumstances shape not only what a person says, but how they say it. In both cases, the approach and attitude of the interviewer helps in establishing a rapport through eye contact, and visual or audible feedback, such as nodding, smiling and making affirmative noises. Using a pre-interview checklist and prompt phrases can be helpful, in ensuring the interviewee knows what to expect. The role of the interviewer is to listen and to participate only insofar as it is necessary to elicit information and guide the interviewee to explore relevant aspects of their story in greater depth. Nevertheless, during the course of an interview the interviewer may be called upon to respond. This could be in the course of regular conversation, such as being asked an opinion, or it might be to support a person who has become distressed or upset. Revisiting the past can be traumatic and difficult, evoking unexpected memories and emotions.[[42]](#endnote-42) It is not unusual for interviewees to become angry, to cry, or to struggle to articulate themselves. Ethics procedures will require you to consider these possibilities and to prepare strategies to cope with situations in advance. This includes knowing where to refer people who need additional help, for example to counselling or support organisations, and what to do if an interviewee appears to be at risk of harming themselves or others.

Interviews vary in length, by design, and by interviewee preference. However, for practical reasons it may be helpful to agree a time limit on an encounter, keeping in mind that transcribing, analysing and interpreting oral histories is time intensive. As a rule, depending on the speed at which a person speaks, an hour’s recording produces 10,000-15,000 words of written content. This takes between four and six hours to transcribe, again depending on factors such as the experience of the transcriber, talking speed, use of specialist language (i.e. technical medical and pharmaceutical words), accent and the coherence of the interviewee’s sentences. Transcription can be outsourced to a third party, but this may not be feasible for cost reasons or because of the sensitive content of the material.

Transcription is another specialist practice and skill implicated in oral history. Interpretive decisions (what is transcribed?) and representational decisions (how is it transcribed?) have wide-ranging implications for the interpretation and analysis of an interview’s content. As Willow Robert Powers explains, “Transcribing any recorded speech is a form of translation,” in which the oral is fixed as text.[[43]](#endnote-43) Whereas written language is an idealised system of grammar, word choice and order, spoken language is messy, broken and syntactically confused. Interviewees will abandon and restart sentences, rephrase themselves, lose their train of thought, contradict themselves, repeat words, misuse words, and communicate using gestures and non-verbal sounds such as laughs, sighs and groans. Translating this onto the page or screen is necessarily interpretative. It may be considered a subjective act, that “reflects transcribers’ analytic or political bias and shapes interpretation of the relationships and contexts depicted in the transcript.”[[44]](#endnote-44) For example, the extent to which the transcriber decides to retain errors, repetitions, dialect words, contractions, linguistic tics and confused expressions change perceptions of the narrative.

Bucholtz defined two principal approaches to transcription, with different potentials and capacities.[[45]](#endnote-45) “Denaturalized” transcription gives oral discourse primacy over written language, and attempts a verbatim depiction of speech. This may include, for example, the inclusion of stutters, pauses, word repetitions, features of oral expression such as ‘erm’ and ‘ah’ and non-verbal signals such as laughter. Features of written language, such as punctuation or paragraphing, are omitted. “Naturalized” transcription, in contrast, applies the conventions of written language to spoken talk, inserting full stops, commas and paragraphs, and may also standardise sentence structures to prioritise sense-making over what was literally said. Naturalized transcription focuses on the substance and content of *what* is said, while denaturalized transcription focuses on *how* it is said. These modes of transcription reflect different ways of locating importance in an interview. Whereas the latter is suited to approaches like critical discourse analysis, which seek to reveal an interviewee’s subjectivity by analysing features of their speech (such as word choice and paralinguistic features like hesitations), the former serves approaches such as thematic content analysis or narrative analysis, which focus on meanings and broader context.[[46]](#endnote-46)

Transcription highlights the paradox of oral histories, which is that they are not purely oral. Both recordings and transcript continue to exist beyond the moment and outside of the context of the interview itself. The future preservation and accessibility of an oral history project in an archive is often seen as a benefit of the method, in supplementing and enhancing the documentary record – filling the archival deficit. Specialist sound and oral history archives actively collect content from local and national projects. For example, the Mental Health Testimony Archive at the British Library is the largest collection of its kind in the UK.[[47]](#endnote-47) The Essex Sound and Video Archive holds a number of oral histories relating to Severalls hospital and other local institutions.[[48]](#endnote-48) University archives and data repositories also store and provide access to oral histories generated by research projects, like the Scottish Oral History Centre at the University of Strathclyde.[[49]](#endnote-49) If your oral histories are intended for long-term preservation this should be decided at the outset, as it may shape some of the decisions that are made during recruitment and transcription.

**Ethics, empowerment and co-production**

All research has ethical implications, but research involving people who may have experienced trauma or systemic oppression, and who may have mental health challenges, brings these implications into sharp focus. Before the oral history interview occurs memories, narratives and stories may not have consciously existed or been articulated. Even where an individual is relatively practiced at telling their story, a new configuration of their history is brought into being during the encounter between the interviewee and the interviewer. Thoughts and meanings that were previously dynamic and unfixed are turned into something which can be repeated and revisited, so that memory and story become available for analysis. In oral history the researcher and the interviewee collaborate on this production of knowledge, because it emerges out of the specific circumstances of their encounter. That encounter is structured by the practical arrangements discussed – the venue, the recording equipment, the questions that are asked – and by the power dynamics which impact on what is said and shared. No oral history takes place in a vacuum. Frisch used the term “shared authority” to describe this relationship, in which the interplay between the interviewer and the interviewee produces the final recording, transcript and interpretation of the past.[[50]](#endnote-50) However, the extent to which authority is truly shared varies and is debatable, depending on the design and implementation of the oral history project. Navigating shared authority presents a particular challenge where there is a significant differential of power between the parties, as may exist between an academic researcher and someone who identifies as a mental health survivor. Indeed, the very concept of the interview may recall the doctor/patient relationship, in which a person is observed and has their testimony recorded, written up and analysed by someone in a position of power. Negative associations with these types of encounters may have emotional implications for some interviewees, impacting on their willingness to take part and what they feel able to share.

The structures and systems of research itself can maintain and exacerbate these existing power imbalances, for example in projects where all of the decisions about a project are made by an academic researcher and the contribution of interviewees is limited to the interview itself. Historians operating in analogous areas of marginalised, community and identity history have advocated models of co-production which reduce distance between the researcher and the researched. They seek to address inequalities of power by collaborating with lived experience co-researchers throughout the research process.[[51]](#endnote-51) For example, Elizabeth Pente and Paul Ward have argued that notions of “shared authority” be expanded beyond the creation of the primary source (the interview) to include a “sustained contribution” to the creation of new knowledge about the past (the oral history process).[[52]](#endnote-52) In oral history this might involve working together with those with lived experience to co-produce a project, from the design of the questions, to the interviewing, interpretation and analysis. This is a model that has already been widely adopted in local and community history projects which take place outside of the university. However, this work requires significant personal and emotional investment over time from all members of the co-production team. Researchers have discussed how these approaches generate new challenges, in relation to the maintenance of boundaries; the development of friendships with lived-experience co-researchers; and the emergence of conflicts within the team.[[53]](#endnote-53)

Some, although by no means all, oral history work is oriented towards justice and aligns to the broader context of critical mental health scholarship and activism. The emergence of Mad Studies as a field of enquiry over the last decade has contested dominant forms of research and knowledge production, particularly those that have traditionally been the focus of psychiatric histories, such as treatments, illnesses and institutions.[[54]](#endnote-54) Oral history methodologies intersect with Mad Studies when they contribute towards ‘survivor research’, through the centralisation of experiential knowledge. Where projects focus on the testimonies of patients and those who have been subject to the mental health system, they may be seen to contribute towards the ongoing work of redistributing power. The interactional and democratising nature of oral history works against the objectivist distance between researcher and researched which Mad Studies considers actively harmful.[[55]](#endnote-55)

Nevertheless, the potential to do harm is ever-present. By their nature, oral histories of psychiatry are highly likely to engage with subjects that are important to a person’s sense of self and wellbeing. This is not only the case with former patients and survivors, but can also be true of medical and mental health practitioners whose reputations, legacies and emotions are implicated in remembering their past work. The potential impact on an interviewee of taking part in research, in the immediate and long term, is considerable. On the one hand, being asked to tell their own stories, in their own words, may be validating. Having previously dismissed or ignored experiences and feelings acknowledged as part of a piece of research can be empowering - the act of sharing may also be therapeutic. However, it may also be distressing, especially where it takes place in the context of ongoing mental health challenges. Being asked to recall painful memories can lead interviewees to revisit trauma, generating difficult and negative emotions in the present. As Glenn Smith, Annie Bartlett and Michael King found in their interviews with LGBTQ+ survivors, the past is not over but continues to impact on mental health in the present.[[56]](#endnote-56) Retraumatisation is a risk and it is important to provide support for participants, which can be accessed afterwards.[[57]](#endnote-57) This may be in the form of access to specialist mental health and counselling services. However, the provision of support should account for concerns and issues of trust which some survivors and former ‘patients’ may have with traditional mental health services. Instead it may be appropriate to refer interviewees to peer support networks and community organisations, outside of formal healthcare structures. At the same time researchers must be mindful of caring for their own physical and mental wellbeing, given the emotional labour of researching difficult subjects and the possibility of vicarious trauma.[[58]](#endnote-58)

**Conclusion**

Oral history has the capacity to transform perspectives on psychiatric and mental health histories, by acknowledging the multiplicity and inconsistency of experiences and understandings of the past. Interviews produce unique sources that can help to fill gaps because archives do not exist or are inaccessible. They can provide access to points of view that have been erased, marginalised or silenced. Where oral history practices seek to redistribute the power in psychiatric systems by centralising the voices of former patients, survivors and ‘mad people’, they can also play a role in empowerment and validation. The intersection of oral history with ‘survivor research’ and Mad Studies, through participation and co-production, can contribute towards socially just approaches to history. These potential benefits arise from the collaborative production of knowledge, which is generated from the “shared authority” between the researcher and those who take part in the research.

However, theoretical and ethical challenges are particularly acute. In her work on community care, *Bedlam in the Streets* (2000), Caroline Knowles wrote that: “In involving ourselves in the lives of others in the course of research, we change them and we change ourselves: we help them write *their* story in specific terms and we rewrite our own in the process.”[[59]](#endnote-59) Political and cultural subjectivities frame every oral history – from the selection of interviewees, to the questions we ask, the way we transcribe and analyse, and how we interpret and present the past to external audiences. A grounding in oral history theory, an attentiveness to practical and technical questions, and ethical self-reflection are important tools to avoid harm and produce histories that serve and tend to the needs of all involved.

1. Richard Cándida Smith, “Analytic strategies for oral history interviews,” in Handbook of Interview Research, eds. Jaber F. Gubrium and James A. Holstein, 711-732 (London: Sage, 2001): 712. [↑](#endnote-ref-1)
2. For the disputed and changing status of oral tradition in history as a discipline, see Jan Varsina, *Oral Tradition as History* (Madison: Wisconsin University Press, 1985); Julie Cruikshank, “Oral tradition and oral history: Reviewing some issues,” *The Canadian Historical Review* 75, no. 3 (1994): 403-418; and Alistair Thomson, “Four Paradigm Transformations in Oral History,” *The Oral History Review* 34, no. 1 (2007): 49-70. [↑](#endnote-ref-2)
3. Rebecca Sharpless, “The History of Oral History,” in *Thinking About Oral History: Theories and Applications*, ed. Thomas L. Charlton, Lois Myers and Rebecca Sharpless, 7-32 (Lanham: Altamira Press, 2008), p. 7. [↑](#endnote-ref-3)
4. Benjamin A. Botkin (ed.), *Lay Down My Burden: A Folk History of Slavery* (Chicago: University of Chicago Press, 1945). [↑](#endnote-ref-4)
5. Michael Frisch, *A Shared Authority: Essays on the Craft and Meaning of Oral and Public History* (Albany: State Univerity of New York Press, 1990), pp. xv-xvi. [↑](#endnote-ref-5)
6. R.K. Grele, “Directions in oral history in the United States,” in D.K. Dunaway and W.K. Baum (eds.), *Oral History: An Interdisciplinary Anthology*, 2nd Edition (Walnut Creek, CA: Altamira, 1996): p. 63. [↑](#endnote-ref-6)
7. See for example, John Adams, “British nurses’ attitudes to electroconvulsive therapy, 1945-2000,” *Journal of Advanced Nursing* 71, no. 10 (2015); Verusca Calabria, “Insider stories from the asylum: peer and staff-patient relationships,” in Joanna Davidson and Yomna Saber (eds.), *Narrating Illness: Prospects and Constraints (*Oxford: Inter-Disciplinary Press, 2016), pp. 1-12; Tracy N. Hipp, Kayla R. Gore, Amanda C. Toumayan, Mollie B. Anderson and Idia B. Thurston, “From conversion toward affirmation: Psychology, civil rights, and experiences of gender-diverse communities in Memphis,” *American Psychologist,* 74, no. 8 (2019): 882–897. [↑](#endnote-ref-7)
8. Robert Perks and Alistair Thomson, *The Oral History Reader*, 3rd Edition (Oxford: Routledge, 2016), pp. xii-xiv. [↑](#endnote-ref-8)
9. Geoffrey Cubitt, *History and Memory* (Manchester: Manchester University Press, 2007), p. 33. [↑](#endnote-ref-9)
10. Italics added for emphasis. Cubitt, *History and Memory*, p. 71. [↑](#endnote-ref-10)
11. Luisa Passerini, *Fascism in Popular Memory: The Culture of the Turin Working Class* (Cambridge: Cambridge University Press, 1987), p. 23. [↑](#endnote-ref-11)
12. E.g. John Wainwright, Mick McKeown and Malcolm Kinney, "“In these streets”: the saliency of place in an alternative black mental health resource centre", International Journal of Human Rights in Healthcare 13, no. 1 (2019): 31-44. [↑](#endnote-ref-12)
13. E.g. Bob Gates and Debra Moore, “Annie’s Story: The Use of Oral history to Explore the Lived Experience of a Learning Disability Nurse in the Twentieth Century,” *International Journal of Nursing History* 7, no. 3 (2002): 50-59; Gail Thomas and Elizabeth Rosser, “Research Findings from the Memories of Nursing Oral History Project,” *British Journal of Nursing* 26, no. 4 (2017): 210-215. [↑](#endnote-ref-13)
14. Tommy Dickinson, *Curing Queers’: Mental health nurses and their patients, 1935-1974* (Manchester: Manchester University Press, 2015). [↑](#endnote-ref-14)
15. Arthur W. Frank, *The Wounded Storyteller: Body, Illness and Ethics*, 2nd Edition (Chicago: University of Chicago Press, 2013), p. 7. [↑](#endnote-ref-15)
16. Roy Porter, “The Patient’s View: Doing Medical History from Below,” *Theory and Society* 14, no.2 (1985): 175-198, 175. [↑](#endnote-ref-16)
17. Dale A. Peterson (ed.), *A Mad People's History of Madness* (Pittsburgh: University of Pittsburgh Press, 1987); Roy Porter, *A Social History of Madness. Stories of the Insane* (London: Weidenfeld and Nicholson, 1989). [↑](#endnote-ref-17)
18. Diana Gittins, *Madness in its Place: narratives of Severalls Hospital, 1913-1997* (London: Routledge, 1998); Jocelyn Goddard, *Mixed Feelings: Littlemore Hospital – An Oral History Project* (Oxford: Oxfordshire Dept of Leisure and Arts, 1996); Caroline Knowles, *Bedlam on the Streets* (London: Routledge, 2000). [↑](#endnote-ref-18)
19. Gittins, *Madness in its Place*, p. 5. [↑](#endnote-ref-19)
20. Raphael Samuel, *Theatres of Memory: Past and Present in Contemporary Culture* (London: Verso, 1994), p8. [↑](#endnote-ref-20)
21. Knowles, *Bedlam in the Streets*, p. 100-133. [↑](#endnote-ref-21)
22. Alistair Thomson, *Anzac Memories: Living with the Legend* (Melbourne: Oxford University Press, 1994), p. 10 [↑](#endnote-ref-22)
23. Luisa Passerini, *Fascism in Popular Memory: The Culture of the Turin Working Class* (Cambridge: Cambridge University Press, 1987). [↑](#endnote-ref-23)
24. Dickinson, *Curing Queers’,* p.12. [↑](#endnote-ref-24)
25. Kerry Davies, “’Silent and Censured Travellers’: Patients’ Narratives and Patients Voices: Perspectives on the History of Mental Illness since 1948,” *Social History of Medicine* 14, no. 2 (2001): 267-292. [↑](#endnote-ref-25)
26. Ibid, p. 268. [↑](#endnote-ref-26)
27. Records of this period may also be less likely to survive in the future, due to the increased formalisation of records management practices, including disposal policies. See for example the current policy and model retention schedules, NHS Digital, *Records Management Code of Practice for Health and Social Care 2016*, <https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016>. [↑](#endnote-ref-27)
28. In the EU and UK data protection legislation is permissive, and there are access exemptions for statistical and historical purposes which may be relevant to some researchers. See The UK National Archives website for the latest advice: <https://www.nationalarchives.gov.uk/archives-sector/legislation/archives-data-protection-law-uk/gdpr-faqs/>. [↑](#endnote-ref-28)
29. Sally Swartz, “Asylum case records: fact and fiction,” *Rethinking History* 22, no. 3 (2018): 289-301. [↑](#endnote-ref-29)
30. Anna Sexton and Dolly Sen, “More voice, less ventriloquism – exploring the relational dynamics in a participatory archive of mental health recovery,” *International Journal of Heritage Studies*, 28: 8 (2008): 874-888, p. 874. [↑](#endnote-ref-30)
31. Patricia Leavy, *Oral History* (Oxford: Oxford University Press, 2011), p. 24. [↑](#endnote-ref-31)
32. Fiona Byrne, “Growing up in ‘The Mental’: childhood experiences at Cavan and Monaghan Mental Hospital on the Irish border, 1930-1950,” *Oral History* 46, no. 2 (2018): 87-96. [↑](#endnote-ref-32)
33. Sheena Rolph, Jan Walmsley and Dorothy Atkinson, “’A Man’s Job’? Gender Issues and the Role of Mental Welfare Officers, 1948-1970,” *Oral History* 30, no. 1 (2002): 28-41. [↑](#endnote-ref-33)
34. Victoria Hoyle, Elizabeth Shepherd, Elizabeth Lomas and Andrew Flinn, “Recordkeeping and the lifelong memory and identity needs of care-experienced children and young people,” *Child and Family Social Work* (2020), https://doi.org/10.1111/cfs.12778 [↑](#endnote-ref-34)
35. Anna Sexton, Andrew Voyce, Dolly Sen, Stuart Baker Brown and Peter Bullimore, *Archive of Mental Health Recovery Stories* (2013), <https://mentalhealthrecovery.omeka.net/>. [↑](#endnote-ref-35)
36. Anna Sexton and Dolly Sen, “More Voice, Less Ventriloquism – exploring the relational dynamics in a participatory archive of mental health recovery,” *International Journal of Heritage Studies* 24, no. 8 (2018): 874-888 [↑](#endnote-ref-36)
37. Patricia Leavy and Lauren Sardi Ross, “The Matrix of Eating Disorder Vulnerability: Oral History and the Link between Personal and Social Problems,” *The Oral History Review* 33, no. 1 (2006): 65-81 [↑](#endnote-ref-37)
38. Hoyle et al.,“Recordkeeping and the lifelong memory and identity needs of care-experienced children and young people.” [↑](#endnote-ref-38)
39. The Oral History Society provides extensive guidance on how GDPR applies to oral history research: <https://www.ohs.org.uk/advice/data-protection/>. [↑](#endnote-ref-39)
40. The Oral History Society provides information on pre-interview preparation: <https://www.ohs.org.uk/advice/ethical-and-legal/2/>. This includes a sample of a recent easy-to-read information sheet for the NHS at 70 project: <https://www.ohs.org.uk/wordpress/wp-content/uploads/NHS-at-70-Participant-Information-Sheet-Revised-April-2019-BL.pdf>. The Health Research Authority also has an interactive guide, with examples, which relates more generally to research with patients and medical practitioners: <http://www.hra-decisiontools.org.uk/consent/>. [↑](#endnote-ref-40)
41. Tommy Dickinson, *Curing Queers’: Mental health nurses and their patients, 1935-1974* (Manchester: Manchester University Press, 2015): 12. [↑](#endnote-ref-41)
42. There is an extensive literature on managing trauma in oral history. As a starting point, see Emma L. Vickers, “Unexpected trauma in oral history interviewing,” *The Oral History Review* 46, no. 1 (2019), 134-141. [↑](#endnote-ref-42)
43. Willow Roberts Powers, *Transcription Techniques for the Spoken Word* (Oxford: Altamira Press, 2005), 9. [↑](#endnote-ref-43)
44. Alexandra Jaffe, “Introduction: Non-standard orthography and non-standard speech,” *Journal of Sociolinguistics* 4, no. 4 (2000): 500. [↑](#endnote-ref-44)
45. Mary Bucholtz, “The politics of transcription,” *Journal of Pragmatics* 32, no. 10 (2000): 1439-1465. [↑](#endnote-ref-45)
46. Daniel G. Oliver, Julianne M. Serovich and Tina L. Mason, “Constraints and opportunities with interview transcription: Towards reflection in qualitative research,” *Social Forces* 82, no. 2 (2005): 1273-1289. [↑](#endnote-ref-46)
47. For more information see the British Library Collections Guide for Disability and Personal and Mental Health: [https://www.bl.uk/collection-guides/oral-histories-of-personal-and-mental-health-and-disability#](https://www.bl.uk/collection-guides/oral-histories-of-personal-and-mental-health-and-disability). Transcripts of the interviews can be found on the original project website, *Testimony: Inside Stories of Mental Health*, available via the Web Archive: <https://www.webarchive.org.uk/wayback/archive/20121113104457/http://www.insidestories.org/>. [↑](#endnote-ref-47)
48. Information on these collections can be found on the Essex Record Office website: <https://www.essexrecordoffice.co.uk/research/sound-video-archive>. [↑](#endnote-ref-48)
49. See <https://www.strath.ac.uk/humanities/schoolofhumanities/history/scottishoralhistorycentre/>. [↑](#endnote-ref-49)
50. Michael Frisch, *A Shared Authority: Essays on the Craft and Meaning of Oral and Public History* (Albany: State Univerity of New York Press, 1990). [↑](#endnote-ref-50)
51. See Sarah Lloyd and Julie Moore, “Sedimented Histories: Connections, Collaborations and Co-production in Regional History,” History Workshop Journal 80, no. 1 (2015): 234-248; Paul Ward, *Britishness since 1970* (London: Routledge, 2004); Elizabeth Pente, Paul Ward, Milton Brown and Hardeep Sahota, “The co-production of historical knowledge: implications for the history of identities,” *Identity Papers: A Journal of British and Irish Studies* 1, no. 1 (2015), <https://doi.org/10.5920/idp.2015.1132>; [↑](#endnote-ref-51)
52. Elizabeth Pente and Paul Ward, “Let’s change History! Community histories and the co-production of historical knowledge,” in *History Making a Difference: New Approaches from Aotearoa* (ed. Lyndon Fraser, Marguerite Hill, Sarah Murray and Greg Ryan), 94-112 (Cambridge: Cambridge Scholarly Publishing, 2017): 94. [↑](#endnote-ref-52)
53. Sexton and Sen, “More Voice, Less Ventriloquism”; Hoyle et al., “Recordkeeping and the lifelong memory and identity needs of care-experienced children and young people.” [↑](#endnote-ref-53)
54. Helen Spandler and Dina Poursanidou, “Who is included in the Mad Studies Project,” *The Journal of Ethics in Mental Health* 10 (2019). [↑](#endnote-ref-54)
55. Alison Faulkner, “Survivor research and Mad Studies: the role and value of experiential knowledge in mental health research,” *Disability and Society* 32, no. 4 (2017): 500-520, 505. [↑](#endnote-ref-55)
56. Glenn Smith, Annie Bartlett and Michael King, “Treatments of homosexuality in Britain since the 1950s – an oral history: the experience of patients,” *British Medical Journal* 328, no. 7434 (2004): 427-429. [↑](#endnote-ref-56)
57. For an example of managing retraumatization in the oral history process, see David Palmer, “Every Morning Before You Open the Door You Have to Watch for that Brown Envelope”: Complexities and Challenges of Undertaking Oral History with Ethiopian Forced Migrants in London, U.K.,” *The Oral History Review* 37, no. 1 (2010): 35-53. For more information on the dynamics of retraumatization, see Robert Reynolds, “Trauma and The Relational Dynamics of Life-History Interviewing,” *Australian Historical Studies* 43, no. 1 (2012): 78-88. [↑](#endnote-ref-57)
58. There is small but growing literature on the emotional labour of oral history work, and the risk of vicarious trauma. A good starting point is Virginia Dickson-Swift, Erica L. James, Sandra Kippen and Pranee Liamputtong, “Researching sensitive topics: Qualitative research as emotion work, “*Qualitative Research* 9, no. 1 (2009):61-79. [↑](#endnote-ref-58)
59. Knowles, *Bedlam in the Streets*, p. 9. [↑](#endnote-ref-59)