Re-inventing the 'cry for help': 'attempted suicide' in Britain in the mid-twentieth century c.1937-1969

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Abstract

After 1945 in Britain there emerges an 'epidemic' of 'attempted suicide' that is read as not aiming at death exclusively, but is instead a form of communication – a 'cry for help'. This 'epidemic' consists predominantly of young people (increasingly gendered female) who present at general hospitals after having taken an amount of medication that is deemed excessive, but insufficient to kill them. This thesis places this 'epidemic' into historical context by looking at two interlinked developments in healthcare provision in Britain. First, models of mental healthcare provision change. With mental health included in the NHS, provision slowly and unevenly moves away from the geographically remote asylum, and into general hospitals and 'the community'. The legislative high point of this process is the 1959 Mental Health Act, removing all legal barriers to mental treatment in general hospitals. This enables consistent psychological scrutiny upon patients presenting at general hospitals. This is cemented by the Suicide Act 1961 which decriminalises suicide and attempted suicide, and is swiftly followed by a government memorandum asking hospitals to ensure that all 'attempted suicide' patients presenting at casualty *receive psychiatric assessment*. The second development is in psychiatric thought, moving towards a socially-focused model of the causation of mental disorder. This is underpinned by broad concepts of 'mental stress' which enable pathology to be located in social relationships and social situations. This is achieved through much intellectual and practical labour, with psychiatric social workers carrying out home visits and follow-up, as well as interviewing friends, relatives and even employers, in order to construct a 'social constellation' around the 'overdose'. Thus, the increased scrutiny at general hospitals recasts that presenting 'physical injury' as a symptom of a disordered social situation, and a *communication* with a social circle: 'a cry for help', newly possible on a nationwide scale.

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Acknowledgements

Introduction

At the London headquarters of the Royal Society of Medicine (RSM) in December 1988, the Section of Psychiatry met to discuss 'suicidal behaviour'. Norman Kreitman and Olive Anderson both spoke on the topic of 'suicide and parasuicide'. At this point, Kreitman was a distinguished psychiatrist, Director of the Medical Research Council's Unit for Epidemiological Psychiatry in Edinburgh, coming to the end of a successful, if unspectacular, career in psychiatric research. Olive Anderson was a Fellow of the Royal Historical Society; her seminal book, *Suicide in Victorian and Edwardian England* had been published the previous year.

Kreitman's paper on prevention strategies strongly differentiates the terms 'suicide' and 'parasuicide', claiming that they 'differ in many radical respects'[1] and that the differences between them 'outweigh their similarities'.[2] This is unsurprising: in 1969 Kreitman and three colleagues had proposed the term 'parasuicide' to describe 'an event in which the patient simulates or mimics suicide'.[3] The term is just one of those proposed in the attempt to classify precisely an 'epidemic' of young people arriving at hospitals across Britain, having taken an overdose of medication insufficient to kill them. Prior to 'parasuicide', the term 'self-poisoning' had been popular, but most popular throughout the period is 'attempted suicide'. This term is modified so that the intent behind the action is not seen as exclusively, or even predominantly oriented towards death, but instead contains elements of communication: a 'cry for help'. Psychiatrist Erwin Stengel is credited by many with founding this new kind of concern around 'attempted suicide'.[4] He sets himself up explicitly *against* the notion that 'a person who has attempted suicide... has bungled his suicide.'[5] Kreitman's 'parasuicide' is one of many interventions reinforcing and rearticulating a *distinction* between acts aimed at causing death, and those motivated by a more complicated and ambiguous intent. However, he is doing it in a specific context: his research from the late 1960s onwards focuses almost exclusively upon people conveyed to hospital after an overdose of medication. The present thesis seeks to historicise this 'epidemic'.

Anderson's paper provides an historical gloss on suicide in Western Europe from the late medieval period to Edwardian Britain. Perhaps prompted by Kreitman's presence, she includes

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[1] N. Kreitman, "Can Suicide and Parasuicide Be Prevented?," *Journal of the Royal Society of Medicine* 82, no.11 (1989): p.650.
[2] Ibid.: p.648.
[3] N. Kreitman et al., "Parasuicide," *British Journal of Psychiatry* 115, no.523 (1969): p.747.
[4] See N. Kreitman, ed. *Parasuicide* (London: John Wiley & Sons, 1977), p.1; W.H. Trethowan, "Suicide and Attempted Suicide," *British Medical Journal* 2, no.6185 (1979), p.320.
[5] E Stengel, "Enquiries into Attempted Suicide [Abridged]," *Proceedings of the Royal Society of Medicine* 45, no.9 (1952): p.613.

a section on '[t]he Victorians and parasuicide.'[6] This interdisciplinary attempt to communicate with clinicians on their terms – and at the RSM no less – is laudable, but the way in which she deploys the concept of 'parasuicide' in an historical paper exposes the deeply problematic relationship that sometimes obtains between history and psychiatry. Her key claim is that '[p]arasuicide is necessarily parasitic on a widely-diffused assumption that self-harming behaviour should be responded to with help, sympathy and remorse, and this cultural breeding-ground flourished in Victorian England.'[7] It is important to be clear on what Anderson is doing here. She is making sense of the behaviour of people in Victorian and Edwardian Britain by using a term fashioned in a 1960s debate over 'communicative overdoses' of medication.

Projecting 'parasuicide' into the past in this way makes the behaviour (as defined by the 1960s terminology) seem timeless, ever-present and unchanging. The historical meaning of human action is flattened into current terminology, a *description that is unavailable* in Victorian Britain. In order for this analysis to work, the notion of a 'widely diffused assumption' homogenises understandings between the late 1980s and the Victorian era. In other words, the behaviour's *meaning* is cast as intended to procure 'help, sympathy and remorse' whether performed at the end of the nineteenth or the end of the twentieth century. The actions described by the term 'parasuicide' in one period are projected into the past. Assumptions and exclusions that create and describe a stereotypical pattern of behaviour (its purpose, possible diagnoses and prognoses, the method employed, the gender, class or age profile, etc.) are transported from one context and imposed upon another.

Though Anderson seemingly makes 'parasuicide' fit, the problems inherent in abstracting the term and projecting it into the past endure. She describes a nineteenth-century process in which the objective in assessing supposedly 'self-destructive' behaviour is to '[t]o distinguish the sham from the real', which is 'a daunting responsibility'.[8] This has superficial resonance with Kreitman's concerns, as when 'parasuicide' is proposed it is claimed that 'what is required is a term for an event in which the patient *simulates* or *mimics* suicide'.[9] However, 'parasuicide' cannot really speak to a debate around 'sham' or 'real'. The term differentiates between a largely uncomplicated wish to die and something much more complicated than mere fakery: 'rarely can his behaviour be construed in any simple sense as oriented primarily

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[6] O. Anderson, "Prevention of Suicide and Parasuicide: What Can We Learn from History?," *Journal of the Royal Society of Medicine* 82, no.11 (1989): p.642.
[7] Ibid.
[8] Ibid.
[9] Kreitman et al., "Parasuicide," p.747. Original emphasis.

towards death... this act, which is like suicide yet is something other than suicide'.[10] All this is lost in the redescription.

The projection of current terms back into history leads to a second problem concerning historical sources. The set of historical phenomena (behaviours) understood through the 'parasuicide' label are accessible because recorded and scrutinised in a particular context; these sources bear scant relation to those that underpin the current term. There is insufficient awareness of the differences between the sources used to speak about 'suicidal behaviour'. These differences have serious consequences for the historical objects described. One of the key sources supporting Anderson's claim that 'recorded suicide attempts far outnumbered registered suicides in Victorian London'[11] is a one-off 'Numerical Analysis of the Patients Treated in Guy's Hospital' (a general hospital) between 1854 and 1861.[12] Information on 'attempted suicide' also comes from various police reports,[13] as suicide is illegal in England and Wales until 1961 (see chapter three). A term produced in the mid-twentieth-century around communicative overdoses brought to NHS hospitals is unsuitable to understand an 'attempted suicide' composite of police records and a one-off hospital analysis. Combining information collected in different ways, for different reasons, and according to different definitions, to make a single object of concern named 'parasuicide' (under a different definition again) constitutes another problematic neglect of context.

The first part of this introduction uncovers similar projections throughout historical and sociological literature on the 'cry for help', showing that Anderson is far from alone in making these leaps. (She is by no means the worst offender, but her interdisciplinary overstretch is a neat example that falls some way short of the thorough, nuanced work in her book.) These projections make sense of a wide range of behaviours by rooting them in some eternal (and often unstated) emotional response or 'distress' or 'widely diffused assumption'. The relationship between the 1960s 'cry for help' and current understandings of 'self-mutilation' or 'deliberate self-harm' is also sketched out. This complex link is understood in direct opposition to any emotional 'constant' giving behaviours the same essential meaning across time. Any such constant obscures the fact that it is most often *currently dominant understandings* that reduce the past to an exemplar of the truth of the present.

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[10] Ibid.

[11] Anderson, "Suicide and Parasuicide," p.642.

[12] Anderson quotes a phrase from this work that resonates with the type of behaviour outlined above: '"a large proportion of so-called suicides do not really meditate self-destruction"; their real desire was "to procure sympathy or to produce remorse."' Ibid.

[13] Ibid. and O. Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon, 1987), pp.263-417.

A fundamental intellectual principle of this thesis is that the historical method described above is deeply problematic. Structuring understandings of the past only through current terminology, constantly updating the significance of the past with each new behavioural category or psychiatric diagnosis, is not an appealing project. This is not to say that 'the past' has a fixed meaning that needs to be uncovered by the diligent and unbiased historian, far from it. The history practiced in this thesis aims to place understandings of behaviour in historical context, to show how practical arrangements and specific intellectual assumptions *create meaning in context*. 'The past' is always a projection of present concerns to a great extent, but this does not necessitate *collapsing* the past into present meanings.

When such contextual meanings, produced through practical arrangements in one context or time period, are imposed upon another, the possibility for meaningful history disappears. These meanings are even more important when considering psychological categories, which ascribe meaning to the actions of human beings who are *aware* that they are being described and labelled in various ways. Through interaction with these powerful diagnostic labels, people can come to *understand themselves* through the motivations and emotions provided by the diagnoses. Telling someone that they are 'unconsciously crying for help' when they profess to be trying to kill themselves can change how that person understands their own actions. Diagnoses can become much more than labels – they can form part of people's identities. If such descriptions are unavailable in a certain context, and the labels are different, the meanings produced are different.

The second part of the introduction opens up these conceptual and philosophical issues about descriptions of behaviour in the past. It begins by asking what precisely the 'cry for help' *is*, before asking how it becomes available to historians in credible ways. The different sources of information (coroners' statistics, police reports, hospital records, etc.) that allow historians to access 'suicidal behaviour' are assessed, and the *consequences* that flow from using different kinds of information are outlined. These differences are a crucial part of the context. Since the nineteenth century, studies of suicide have been largely based upon well-established judicial registration procedures (coroners' statistics) from which a picture of 'suicide' is formed. No such registration practices exist for 'attempted suicide' in this period. From the late 1930s until the proposal of the term 'parasuicide' in 1969 this phenomenon of a 'cry for help' emerges from *hospitals* which are very different indeed from coroners' offices.

The easy combination of material from very different sources (highlighted in Anderson's combination of hospital and police records to produce 'parasuicide') also occurs in the literature between coroners and hospitals, between 'suicide' and 'attempted suicide'. The

distinction between two sources of information is collapsed, and then rearticulated through a form of technological determinism. This literature (predominantly concerning North America) comes to argue that the difference between 'attempted' and 'successful' suicide lies in how far different groups of people have differing access to 'lethal' methods (crudely, men use guns and women use pills). This is problematic in a different way, and will be analysed below.

Having focused upon the problems with current literature, we then turn to the specifics of this thesis. The context right at the core of this work is one which enables patients who arrive at hospitals, having suffered a physical injury, to be *assessed by psychological and psychiatric clinicians*. It is this psychological expertise, and the assumptions contained within it, that enable the presenting 'physical injury' (in this period, an overdose of medication) to be transformed into a pathological communication, a symptom of a disordered social environment, a 'simulation', or a 'cry for help'. The possibilities for patients arriving at general hospitals to get consistent psychiatric assessment expand rapidly in this period. From the middle of the nineteenth century, much of British psychiatric practice is focussed upon the more remote mental asylums. The Mental Health Act 1959 is a familiar landmark in twentieth-century psychiatric history, representing a shift from this segregated model of provision. However, its impact in removing all legal obstacles for psychiatric treatment at *general hospitals* (where most 'attempted suicides' are taken in the first instance, if at all) has been obscured by the dominant story of the failures of 'community care' for the mentally ill coming out of *psychiatric hospitals*. In other words, the growing possibility of getting psychiatric treatment at a general hospital (which is not 'the community' or an asylum) is absolutely crucial in the rise of this psychological object to national prominence.

The third section focuses upon the specifics of this psychiatric assessment. The place of the 'social environment' in mid-twentieth-century psychiatric thought (and especially psychiatric epidemiology) is of paramount importance in Britain. Thus, *historically specific types* of psychological expertise recast 'physical injury' as a symptom of 'pathological social relationships'. The 'cry for help' emerges from a psychiatric tradition that focuses upon the social environment and psychiatric illness as communication. The idea of a 'cry for help' might well have a broad intellectual ancestry, but it is structured and articulated by much more immediate intellectual and practical concerns. If this behaviour is *not* eternal and ever-present (something implied by projecting it back through history), then this specific phenomenon of a 'cry for help' must be more precisely delineated. This is achieved in the final part of the introduction through analysis of two psychiatric textbooks in which understandings of 'suicidal behaviour' shift, and the socially-directed, communicative 'attempt' not solely focussed upon death can be pinned down more securely.

Projections into the past: historical literature on the 'cry for help'

Literature that engages historically or sociologically with the specific twentieth-century object 'overdose as cry for help' is rare. Studies that do mention it suffer from a high level of conceptual confusion. The predominant approach is either explicitly or implicitly to presume an 'eternal undercurrent' that is presumed to animate the so-called 'distress behaviour' across time (such as Anderson). There are also studies that attempt to collapse distinctions between 'suicide' and 'attempted suicide'. Finally, Jack D. Douglas' *The Social Meaning of Suicide* (1967) uses the work of Erwin Stengel on 'attempted suicide' to undercut official suicide statistics and critique Durkheimian studies of suicide. His uncritical acceptance of Stengel's collaboration with social workers who perform home visits (as simply providing more accurate information about suicidal behaviour) is problematic. These practices and professionals (in Stengel's work and others') are placed firmly in their historical context in this thesis.

Anderson's imposition of 'parasuicide' is especially clear in the second decade of the twenty-first century, as the term has fallen out of fashion. Never popular enough to be widely understood by non-medical audiences, it has been largely forced from view by competing understandings of behaviour under the labels 'self-injury', 'self-harm' or 'self-mutilation'. In the early twenty-first century, behaviour interpreted as intentionally harmful to oneself, and yet not directed at ending life, stereotypically involves young people cutting their forearms with sharp objects.[14]

It might be argued, reinforcing Anderson's analysis, that current 'self-injury' concerns, the 'parasuicide' epidemic of the 1960s and 1970s and Victorian 'attempted suicide' are indeed largely 'the same thing', and form an unbroken chain back into the past. Such claims are made by current experts on 'self-mutilation' such as Armando Favazza who argues that 'self-mutilation' has existed as long as humans have existed, finding it in 'Tibetan Tantric Meditation, North American Plains Indian mysticism and the iconography of Christ's Passion.'[15] Jan Sutton, another twenty-first century expert on 'deliberate self-harm' (DSH) claims that '[d]eliberate self-harm, parasuicide and attempted suicide… essentially they all refer to the same behaviour, and are sometimes used interchangeably.'[16] As noted, this position is

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[14] B. Brickman, ""Delicate" Cutters: Gendered Self-Mutilation and Attractive Flesh in Medical Discourse," *Body and Society* 10, no.4 (2005); C. Millard, "Self-Mutilation and a Psychiatric Syndrome: Emergence, Exclusions & Contexts (1967-1976)" (MA, University of York, 2007).

[15] A.R. Favazza, *Bodies under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry*, 2nd ed. (Baltimore: Johns Hopkins University Press, 1996), pp.2, 11-16.

[16] J. Sutton, *Healing the Hurt Within: Understand Self-Injury and Self-Harm, and Heal the Emotional Wounds*, 3rd ed. (Oxford: How To Books, 2007), p.108.

problematic.[17] In the 1960s, eminent toxicologist Sir Derrick Melville Dunlop[18] performs a similar projection using notions of 'hysteria':

> 'different generations tend in certain respects to vary in their patterns of behaviour. Thus, in Victorian times and in the earlier part of this century, in order to escape from a situation which had become intolerable, it was common, especially for younger women, to develop "the vapours" - crude hysterias, fits, palsies, catalepsies and so forth. These hysterical manifestations are rare nowadays: it is easier to take a handful of tablets... not usually with any true suicidal motive but rather just to seek oblivion from, or to call attention to, unhappiness'[19]

Such a narrative involves a different vision of the Victorian period to Anderson's. However, the presumption of a pattern that *only varies on the surface, if at all,* is common to both methods of unifying the present and the past. They both use the past to anchor currently valid methods of sense-making.

That a relatively durable meaning might be stubbornly projected into many diverse behaviours – from catalepsies and fits to taking 'a handful of tablets' – does not make it somehow eternal. That the 'cry for help' might 'seem to recur predictably' – to borrow from Joan Scott – does not insulate it from history, as not only are the 'specific meanings... conveyed through new combinations',[20] but the very assumption of identity needs to be thoroughly investigated. An appreciation of these sense-making strategies instead sharpens awareness of *what is at stake* in projecting these kinds of histories to anchor these kinds of behaviours.

Eminent and prolific psychiatrist and historian German Berrios calls chapter 19 of his *History of Mental Symptoms* 'self-harm' whilst talking exclusively about 'suicide'. He risks serious confusion in the present (both in 1996 when the book was published and now, in 2012) by conflating two categories that have been fairly well separated in Britain since the late 1980s, because he does this without any explanation, talking of '[e]arly nineteenth century views on

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[17] Sarah Chaney investigates the contextually specific meanings of 'self-mutilation' in Victorian psychology. S. Chaney, ""A Hideous Torture on Himself": Madness and Self-Mutilation in Victorian Literature," *Journal of Medical Humanities* 32 (2011) pp.279-289.

[18] Most famous for the 'Dunlop Committee' on drug safety established in 1964 following the Thalidomide disaster (chapter four).

[19] D.M. Dunlop, 'Foreword' to H.J.S. Matthew and A.A.H. Lawson, *Treatment of Common Acute Poisonings* (Edinburgh: E. & S. Livingstone, 1967), p.iv.

[20] J.W. Scott, *Gender and the Politics of History,* Rev. ed. (New York: Columbia University Press, 1999), p.7.

suicide or self-harm'.[21] This confusion stems from the failure to appreciate that these descriptions relate to specific problems in specific historical contexts. Thus he translates the term 'suicide simulé' from nineteenth-century French alienist Jean-Etienne Esquirol as "para-suicide".'[22] The confusion in Berrios' work also seems to stem from his idea that the 'one obvious thing to do, when faced with multiple levels of explanation, is blend them'[23] which necessitates an unmentioned but self-evident intention to hold everything together. There is no sense that Berrios believes that these meanings are anything other than self-evident.

Raymond Jack's *Women and Attempted Suicide* (1992) treats the 'attempted suicide epidemic' of 1948-c.1980 as a relatively discrete historical and sociological phenomenon. He begins by claiming that 1960s social change accounts for 'the historical fluctuations in female self-poisoning',[24] but this focus on specificity ends up as trans-historical explanation. He makes sense of what he calls 'self-poisoning' (a term most influential prior to Krietman's 'parasuicide', during the mid-1960s) by linking it to 'hysteria' in a manner reminiscent of Dunlop: '[a]s we have seen, female self-poisoning has frequently been explained in terms of the hysterical personality supposedly common among its perpetrators'.[25] He reproduces the comment that 'its form - unconsciousness and physical dependence - has even, in a brief aside, been compared with that of the swooning of the hysterical woman.'[26] When discussing 'hysteria' he argues that '[t]he parallels with the 20th century epidemic of female self-poisoning… are striking.'[27] Thus, his attempts to situate this epidemic historically, rooted in the 'intense change in women's domestic and social roles' that he supposes happens during the 1960s ultimately fail.[28] The 1960s *is* a specific context, but not drawn in enough detail to support any analytical argument. Thus, in Jack's explanation for the epidemic of 'self-poisoning', this context is undermined and ultimately rendered irrelevant by the parallels with 'hysteria'. 'Self-poisoning' and 'hysteria' are *both* reduced to mere variations of some timeless emotional impulse.

This flaw has other consequences, causing confusion over why people in the past do not differentiate between (and therefore constitute) 'suicide' and 'attempted suicide' in the currently dominant ways. Jack bemoans 'the tendency to regard all non-fatal acts of deliberate self-harm as failed suicides [which] characterises most of the psychiatric literature, at least up

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[21] G. E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge: C.U.P., 1996), p.443.
[22] Ibid., p.445.
[23] Ibid., p.450.
[24] R. Jack, *Women and Attempted Suicide* (Lawrence Erlbaum, 1992), p.76.
[25] Ibid., p.72.
[26] Ibid. quoting W. McCulloch and A.E. Philip, *Suicidal Behaviour* (Oxford: Pergamon, 1972).
[27] Jack, *Women and Attempted Suicide*, p.76.
[28] Ibid.

until the 1960s.'[29] This is despite the fact that according to him, 'some commentators had shown an awareness of the differing nature of the two behaviours and their motivation long before'.[30] For Jack this 'makes the persistence of the confusion [between 'suicide' and 'attempted suicide'] more puzzling.'[31] A particular instance of his confusion involves Esquirol, one of the past 'commentators' supposed to have demonstrated 1960s-esque differentiations between 'suicide' and 'attempted suicide'. Jack presents the following unanalysed quotation from Esquirol's *Des Maladies Mentales* (1838): 'Of 100 persons who attempt suicide only 40 succeed'.[32] The relevance of this statement is self-evident because Jack so readily equates concepts across time and space (not to mention national contexts and different languages). Because this is so obvious to him, historical changes in definition are 'puzzling'. David Aldridge also draws attention to a certain lack of clarity. He notes that 'Stengel (1958) drew a clear boundary between 'attempted' and 'completed' suicide.'[33] He goes on to say that 'in reality those distinctions have become blurred by subsequent investigations.'[34]

Jack's 'confusion' and the 'blurring' mentioned by Aldridge stem precisely from the kind of analysis that equates current concepts (and their contextual baggage) to past phenomena produced in potentially very different ways, for different purposes, through different practices, and undergirded by different assumptions. This conceptual presentism cannot deal adequately with historical change and must assume something 'real', that is, *constant*, and self-evident across time, underneath the different terms in different contexts. Aldridge explicitly claims that '[s]uicide and suicide attempts are not so distinct... By concentrating on describing static discrete characteristics of stereotypical populations, the essential dynamic process of becoming suicidal has been missed.'[35] The idea that people might be dealing with different, equally legitimate but radically contextually specific objects, in different places, at different times, appears not to occur to him. Michel de Certeau observes that historical change means that '[t]here will thus be *facts* that are no longer *truths*.'[36] The presumed and projected undercurrent turns all the 'facts' of the past into examples of present 'truths', rather than seeing all 'facts' as 'truths' in the contexts that produce them. Thus the differences are rendered as the 'confusion' or 'blurring' of an 'essential dynamic process', which operates regardless of time and space. Appropriately historical questions might concern how and when these differentiations – so clearly set out by Stengel – lose their analytical power, or how and

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[29] Ibid., p.12.
[30] Ibid.
[31] Ibid.
[32] Ibid.
[33] David Aldridge, *Suicide: The Tragedy of Hopelessness* (London: Jessica Kingsley, 1998), p.12.
[34] Ibid.
[35] Ibid., p.13.
[36] Michel de Certeau, *The Practice of Everyday Life* (University of California Press, 1984), p.11.

why historical circumstances change so that *different* readings of 'self-destructive' behaviours appear self-evident.

How did 'attempted suicide' become an object of study, and what kind of object is it?[37]

The descriptions and analyses of 'attempted suicide' critiqued above provoke further historical and philosophical questions. Reversing Ruth Leys' formulation, borrowed for this section's heading, the first question to be asked is: what precisely do we mean by saying that 'attempted suicide' or 'parasuicide' or 'hysteria' happened in the past? What kind of object *is* 'attempted suicide' in the past? Having answered these questions, it is possible to discuss the *implications* of apprehending the past in these ways. Then we can see *how* attempted suicide comes to be an object of study – i.e. how it is recorded, treated and accessed as a statistical or clinical concern. This can explain how 'an epidemic of attempted suicide' becomes possible, prompting important questions about how and why human beings might behave in certain ways, at certain times.

What kind of object is it? Redescription of the past

In order to achieve a working definition of what 'attempted suicide' is, it is useful briefly to revisit a debate in 2002-03 around Chapter 17 of Ian Hacking's *Rewriting the Soul*, entitled 'An Indeterminacy in the Past'.[38] This debate focuses on whether redescription of actions in the past using present categories (like Anderson's use of 'parasuicide' to describe actions in Victorian Britain) is legitimate, and whether it changes the actions. Hacking's examples include: are Canadian soldiers shot for desertion during the First World War now sufferers from post-traumatic stress disorder (PTSD)?[39] Is an eighteenth-century, forty-eight-year-old Scottish explorer a 'child molester' for marrying a fourteen-year-old girl?[40]

The legitimacy and consequences of various redescriptions (called 'retroactive' because they act 'backwards' upon the past) are analysed through Hacking's engagement with influential Wittgensteinian philosopher G.E.M. Anscombe's *Intention* (1957).[41] The most relevant point in Anscombe's argument to Hacking's project (and what emerges in the debate), is the focus upon *context*. Hacking engages with Anscombe's key example of a 'man pumping water'. He states that

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[37] This particularly clear way of formulating what is quite a tangled epistemological issue is inspired by the title of Ruth Leys' article: R. Leys, "How Did Fear Become a Scientific Object and What Kind of Object Is It?," *Representations* 110(2010).

[38] I. Hacking, *Rewriting the Soul* (Princeton: Princeton University Press, 1995), pp.234-267.

[39] See also ———, "Indeterminacy in the Past," *History of the Human Sciences* 16, no.2 (2003): pp.121-123.

[40] Hacking, *Rewriting*, pp.242.

[41] G.E.M. Anscombe, *Intention* (Oxford: Basil Blackwell, 1957), p.84.

'[o]ne of the ways in which human action falls under descriptions is in terms of the way the action fits into a larger scene. The man's hand on the pump is going up and down. Enlarge the scene. He is pumping water. Enlarge the scene. He is poisoning men in the villa. As Anscombe makes so plain, the intentionality of an action is not a private mental event added on to what is done, but is the doing in context.'[42]

Kevin McMillan's contribution to the debate makes this contextual point especially clear. He argues that we can get a handle on what 'social phenomena' (for example, an 'epidemic of attempted suicide') might be, by 'identifying and distinguishing them in terms of their historical, cultural or domain specificity.'[43] He realises that this has consequences: '[a]n emphasis on specificity may make us chary of indiscriminate retroactive redescription. When applied, redescriptions – particularly in terms of modern moral concepts – drag a complex and extensive practical, moral, epistemic and conceptual baggage in tow.'[44] It is an appreciation of this 'baggage' that is crucial to understanding 'attempted suicide' in a fully *historical* way – to be wary of describing past actions with current concepts.

In the case of 'attempted suicide' the situation is a little more complicated. Whilst Anderson and Berrios use current terms to redescribe the past in language not available at the time, Dunlop and Jack are doing something subtly different. This is clearest in the passage of Dunlop, quoted above, where he associates 'self-poisoning' and 'hysteria'. He is *not* redescribing hysteria as taking 'a handful of tablets' (the stereotypical behaviour for this 'attempted suicide'), he claims instead that they *stem from the same root*. He is opening up *both* behaviours for redescription, by projecting an underlying – and unexamined – constant that animates responses to 'intolerable' situations.[45]

Following this line of analysis means that 'attempted suicide' cannot exist as a concept or pattern of behaviour *independent* of the institutional channels and professional scrutiny through which it is constituted. Specifically, this involves the increasingly consistent provision of psychiatric scrutiny available to patients presenting at general hospitals (as we shall see below). To separate the object 'attempted suicide' from these practices would be to divorce it from its context. Following Allan Young's argument around PTSD, it is argued here that 'attempted suicide' 'is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies and narratives with which it is diagnosed, studied,

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[42] Hacking, *Rewriting*, p.248.
[43] K. McMillan, "Under a Redescription," *History of the Human Sciences* 16, no.2 (2003): p.136.
[44] Ibid.
[45] Dunlop "Foreword," p.iv.

treated, and represented and by the various interests, institutions and moral arguments that mobilized these efforts and resources.'[46] Particular practices and technologies (new arrangements for psychological scrutiny) create 'attempted suicide as cry for help.' This is not to say that people in the past have not used the term 'attempted suicide' or that they are wrong to do so. However, *they are not talking about, recording or accessing the same thing*.

It is negligent to collapse the diverse richness of past subjectivities into the psychological (or neurobiological, sociological, etc.) categories that happen to be current today. Adrian Wilson argues that 'concepts-of-disease, like all concepts, are human and social products which have changed and developed historically, and which thus form the proper business of the historian'.[47] He describes the consequences of retroactive redescription, which results in an approach:

> 'in which diseases throughout history have been identified with their modern names-and-concepts... the effect of this approach is to construct a conceptual space in which the historicity of all disease-concepts, whether past or present, has been obliterated. Past concepts of disease have simply been written out of existence; and the historicity of modern disease-concepts (or what are taken to be modern ones) is effaced, because those concepts have been assigned a transhistorical validity.'[48]

This effort to homogenize and assimilate might well have a present utility, as well as broadly progressive political effects, as in the case of Canadian deserters and PTSD. However, in order for objects to have such a transhistorical and decontextualised existence, their conditions of production must be obscured; in other words, they only make sense outside of past context – utterly unhistorical. Thus the meaning of 'attempted suicide' is more precisely stated: a specific understanding of behaviour, inseparable from its context. Having established the importance of context *in general*, the specifics of 'attempted suicide' can now be tackled, by comparing the different historical and institutional contexts through which 'suicide' and 'attempted suicide' are accessed in Britain in the nineteenth and twentieth centuries.

Coroners, asylums and general hospitals: different kinds of suicide object

Objects labelled 'suicide' and 'attempted suicide' can be found in the nineteenth century and long before. Mid-twentieth century 'suicide' strongly resembles its nineteenth-century

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[46] Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995), p.5.

[47] A. Wilson, "On the History of Disease Concepts: The Case of Pleurisy," *History of Science* 38(2000): p.273.

[48] Ibid.

counterpart in how it is accessed and the (coroners' court) sources upon which it is based. However, objects called 'attempted suicide' in the nineteenth and in the twentieth centuries are separated by a profound difference. Within *both* time periods, comparison of the sources of information for 'suicide' (coroners' records) and 'attempted suicide' (asylum, police and/or hospital records) reveal radical differences, with far-reaching consequences.

Nineteenth-century suicide: coroners

In histories of statistics, coroner-based suicide studies have an eminent place. In *The Taming of Chance* Ian Hacking notes that '[b]y 1830 innumerable regularities about crime and suicide seemed visible... No one would have imagined such statistical stabilities had it not been for an avalanche of printed numbers and tables.'[49] This is perhaps the key point about suicide as an object for study: it is only accessible through statistical, administrative practices that record it. According to Hacking, these practices are rooted 'in the notion that one can improve – control – a deviant subpopulation by enumeration and classification.'[50] 'Suicide' seems a fairly consistent, regular and self-evident phenomenon because in some Western European countries, records of deaths specify whether the death is judged a result of suicide or not, and have done for a considerable period. Whilst this establishes its apparent self-evidence, it must not be forgotten that '[s]tatistical laws that look like brute, irreducible facts... could be noticed only after social phenomena had been enumerated, tabulated and made public.'[51]

The coroner's court 'is one of the oldest courts in England and Wales',[52] but the role of the state in registering deaths is only formalised in 1836 by the Births and Deaths Registration Act. In 1887, the Coroners Act delineates a coroner's jurisdiction as deaths thought to be 'violent', 'unnatural' or 'sudden', as well as statutory requirements to investigate deaths on roads, railways and in prisons. The Births and Deaths Registration Act of 1926 makes it 'an offence to dispose of any body without a registrar's certificate for disposal or a coroner's order'.[53] Coroner's courts differ from standard law courts: it is usual for the coroner to read from completed statements provided by witnesses, and checking with the witnesses (under oath) that the statements are correct. The most important point for the present thesis is that when a death occurs, large and specialised legal machinery is brought into play in order to tabulate and assess it, including bringing in witnesses under oath. This is allied to penalties for disposing

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[49] I. Hacking, *The Taming of Chance* (Cambridge: C.U.P., 1990), p.73.

[50] Ibid., p.3. Elsewhere, he claims that '[s]uicide was tabulated because it was a Bad Act, perhaps the very worst, beyond the possibility of repentance and even forgiveness.' ———, "The Looping Effects of Human Kinds," in *Causal Cognition: A Multidisciplinary Debate*, ed. D. Sperber, D. Premack, and A.J. Premack (Oxford: Clarendon Press, 1995), p.355.

[51] Hacking, *Taming*, p.3.

[52] J. M. Atkinson, *Discovering Suicide: Studies in the Social Organisation of Sudden Death* (London: Macmillan, 1978), p.101. The following paragraph is heavily indebted to Ibid. pp.93-103.

[53] Ibid. p.95.

of a body without notifying the relevant authorities. None of these practices exist for 'attempted suicide'. Additionally, suicide is a felony under the law until 1961 and there exists a formal legal obligation to report it, whereas 'attempted suicide' is a misdemeanour, for which there is no corresponding obligation.[54]

All this effort producing 'suicide' as a statistical object has consequences. Joan Scott argues that statistics are 'ways of establishing the authority of certain visions of social order, or organising perceptions of "experience"'[55] which means that suicide statistics are not self-evident 'givens', but an argument for a specific conception of the world. Hacking develops his analysis about the relationship between 'social phenomena' and statistics in this direction, asserting that '[t]he laws had in the beginning to be read into the data. They were not simply read off them.'[56] Historical circumstances do more than just 'frame' or 'highlight' suicide as the currently recognisable object of study – they constitute it. This crucial point bears repetition: the phenomena (in this case 'suicide') that statistics purport to 'show' are constituted by the practices through which they are collected and made intelligible.[57] It is thanks to these procedures that Emile Durkheim produces his 'rates' of suicide in the late nineteenth century from published statistics,[58] conducting no fieldwork of his own (even those who do, like Enrico Morselli, rely upon access to coroners' records).[59]

Nineteenth-century 'attempted suicide': asylums, et cetera

'Attempted suicide' does not show up in coroners' records. An object under that label does exist in the nineteenth century, but comes from a variety of sources. Anne Shepherd and David Wright use the most popular set of source materials used to access these 'suicide attempts', county asylum records. They argue that these provide 'a useful comparison to the more frequently used coroners' reports that underpin most research on Victorian suicide.'[60] They describe:

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[54] 'Felonies should be reported to the police, and there is no doubt that successful suicide, as opposed to attempted suicide, is a felony.' Church Information Office, *Ought Suicide to Be a Crime? A Discussion on Suicide, Attempted Suicide and the Law* (Westminster: Church Information Office, 1959), p.10. Also: '[a]t common law, an attempt to commit a crime is a misdemeanour, even if the crime attempted is (like murder) a felony. Attempted murder was made a felony [against this general principle] by the Offences against the Person Act, 1861, but it has been judicially decided that attempted suicide is not attempted murder within the meaning of that [1861] statute.' Ibid.

[55] Scott, *Politics of History*, p.115.

[56] Hacking, *Taming*, pp.3-4.

[57] J.D. Douglas, *The Social Meanings of Suicide* (Princeton: Princeton University Press, 1967); Atkinson, *Discovering Suicide*.

[58] Emile Durkheim, *Suicide, a Study in Sociology* (Glencoe: Free Press, 1951).

[59] 'Durkheim's classic and originating work *Suicide* could draw upon 80 years of studies.' Hacking, "Looping Effects," p.355.

[60] A. Shepherd and D. Wright, "Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint," *Medical History* 46, no.2 (2002): p.193.

'a dominant and influential tradition of researching the history of self-murder from death certificates, coroners' reports, and official parliamentary statistics. We thus know a great deal about those who were 'successful', but much less about those who had 'failed' to take their own lives. Attempted self-murder remains relatively uncharted territory.'[61]

Shepherd and Wright do not elaborate upon the differences between the various registration practices, and the consequences flowing from the different kinds of access to 'failed' or 'successful' objects in the past. However, they do suggest that the label 'suicidal' includes both 'real' and 'fake' attempts, and is therefore ambiguous.[62]

Åsa Jansson's conceptually precise study of 'suicidal propensities' in nineteenth-century psychiatric literature and asylum casebooks demonstrates the fundamental relationship between recording practices and conceptual possibilities, concluding that there is no easy relationship between the adjective 'suicidal' and the noun 'suicide' in this period. This position is based upon a clear and consistent appreciation of the different recording and statistical practices that underpin the different objects denoted by those words.[63] Sarah Chaney's study of suicide at Bethlem (1845-1875) is thorough and detailed, including sustained efforts to access and analyse meanings around 'attempted suicide'. Even so, Chaney laments 'the lack of reliable statistical evidence'[64] and quotes (but also contests) the assessment of Michael Macdonald who claims that '[a]ll that can be said about attempted suicides is that in England they frequently received medical care even before the nineteenth century, and that suicidal men and women were increasingly confined in public and private asylums.'[65] During the nineteenth century and before, information about 'attempted suicide' does not come from so organised and systematic a source as coroners, who record and categorize the dead, not the living 'attempter'.

The information that is recorded about 'attempted suicide' (including the forms in which it is collected, the people collecting it and the purposes for which it is collected) is very different

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[61] Ibid.: p.179. Shepherd and Wright use 'self-murder' because 'suicide' seems too 'psychiatric'. See also Sarah Haley York, 'Suicide, Lunacy and the Asylum in Nineteenth-Century England' (PhD thesis, University of Birmingham, 2009) which is explicitly set up as a continuation of Shepherd and Wright's article.

[62] Ibid.: pp.194-196.

[63] Å. Jansson, "From Statistics to Diagnostics: Medical Certificates, Melancholia, and "Suicidal Propensities" in Victorian Medicine," *Journal of Social History* 46, no.3 (2013 [forthcoming]).

[64] S. Chaney, "Suicide, Mental Illness and the Asylum: The Case of Bethlem Royal Hospital 1845-1875" (MA Dissertation, University College London, 2009), pp.4-5.

[65] Ibid., p.5. quoting M. MacDonald, "Suicidal Behaviour: Social Section," in *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, ed. R. Porter and G.E. Berrios (London: Athlone, 1995), p.629.

indeed from that collected and recorded for 'completed suicide'. Peter Sainsbury's study, the most influential study of suicide in Britain in the twentieth century, is explicitly Durkheimian, and continues to draw from these long-established registration procedures (coroners' court proceedings) to gather data about suicide. Erwin Stengel takes a different path to the asylum statistics, primarily using mental observation wards attached to general hospitals, places significantly associated with 'attempted suicide'. These are parts of general hospitals where psychiatric scrutiny is available. This crossover point between general and psychiatric medicine, along with the inclusion of mental health services in the NHS, forms an absolutely crucial specific historical context for the emergence of 'attempted suicide'. As coroners' courts continue to benefit from much legal and administrative machinery to produce statistics of 'suicide', a clinical object of 'attempted suicide' begins to grow in a different context, based upon the psychiatric scrutiny and assessment of patients brought to general hospitals having suffered an injury presumed as 'self-inflicted', principally at these mental observation wards. A number of psychiatrists, including Frederick Hopkins in Liverpool (1937-1943), Erwin Stengel in London (1952-1958) and Ivor Batchelor in Edinburgh (1953-1955) begin to exploit the uneasy cohabitation of general medical and psychiatric expertise in these 'secure' areas connected to various general hospitals.[66]

Twentieth century: between coroners and observation wards

Coroners and social statistics

The context of Stengel's and Sainsbury's researches and the objects that they access and constitute are fundamentally different. Peter Sainsbury enjoys a stellar career in psychiatric epidemiology, starting out under the mentorship of Aubrey Lewis.[67] His *Suicide in London* (1955) is a 'minor classic'[68] and he is appointed Director of the MRC Clinical Psychiatry Unit at the Graylingwell Hospital, Chichester in 1957. By 1971, according to his colleague D.J. Pallis, he is 'Britain's foremost "suicidologist".'[69]

Sainsbury's interest in suicidal behaviour is aroused when working as senior registrar on St Francis' observation ward (1947-1949).[70] He recalls that the ward 'provided a wonderful experience in acute psychiatry and I enjoyed it, especially Professor [Aubrey] Lewis' fortnightly

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[66] F. Hopkins, "Attempted Suicide: An Investigation," *Journal of Mental Science* 83(1937): pp.71-94; Stengel, "Enquiries into Attempted Suicide [Abridged],"; I.R.C. Batchelor and M.B. Napier, "Broken Homes and Attempted Suicide," *British Journal of Delinquency* 4(1953): pp.99-108.
[67] D.J. Pallis, "Peter Sainsbury," *Psychiatric Bulletin* 28, no.10 (2004): p.391.
[68] B. Barraclough, "Peter Sainsbury," in *Munk's Roll* (London: Royal College of Physicians of London, 2004), p.495.
[69] Pallis, "Peter Sainsbury," p.391.
[70] Barraclough, "Peter Sainsbury," p.495.

visits to advise us on the more difficult cases'.[71] Sainsbury's recollections show the ward's association with 'attempted suicide':

> 'One day, I told him [Lewis] I was perplexed by the suicide attempters and indeed why people killed themselves. This set him off saying "Oh Sainsbury, haven't you read Faris and Dunham?", "No sir", "Do you know Durkheim's work on suicide?", "No", "Do you know Booth's survey of London?", "No", "Oh well, you might find something interesting there." It took me a year to see what he was getting at, to read these books and to gather that he was suggesting that I did some kind of social epidemiological survey of suicide'[72]

The studies to which Lewis refers associate 'social statistics' with geographical areas – social epidemiology. Booth maps 'poverty' in London, Durkheim maps 'suicide' in France and Faris and Dunham map 'mental disorder' in Chicago.[73] Sainsbury decides to map suicide in London.[74] Even though his studies of suicide involves very different data, the 'suicide attempters' on St. Francis' observation ward are his first clinical encounter with such a defined or crystallised phenomenon. It is on an observation ward, rather than at Bexley Mental Hospital, where he works immediately prior (and where he takes his Diploma in Psychological Medicine, the standard psychiatric qualification at the time) that 'suicide attempters' become an issue. When pressed to account for his interest in suicide, Sainsbury does not give Lewis all the credit, mentioning the kinds of cases brought to his attention by particular surroundings: 'I often think of this encounter with Aubrey and wonder why I was interested in suicide. Prior to joining the observation ward, I never had to talk and cope with people who had seriously wanted to kill themselves.'[75]

He relates of *Suicide in London* that 'I realised I was on a good wicket, that there was not only an immense reservoir of statistics on suicide but also of social data on the London boroughs... here was a wealth of information which could be easily exploited.'[76] The first part of Sainsbury's study involves calculating the 'suicide rates of the twenty-eight boroughs in

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[71] G. Wilkinson, *Talking About Psychiatry* (London: Gaskell, 1993), p.138.

[72] Ibid.

[73] See R.E.L. Faris and H.W. Dunham, *Mental Disorders in Urban Areas: An Ecological Study of Schizophrenia and Other Psychoses* (Chicago: University of Chicago Press, 1939); Durkheim, *Suicide, a Study in Sociology*; C. Booth, *Labour and Life of the People*, 2 vols., vol. 1 (London: Williams and Norgate, 1889); ———, *Labour and Life of the People*, 2 vols., vol. 2 (London: Williams and Norgate, 1891).

[74] P. Sainsbury, *Suicide in London: An Ecological Study* (London: Chapman & Hall, 1955).

[75] Wilkinson, *Talking*, p.138.

[76] Wilkinson, *Talking*, p.138. He acknowledges a debt to Sir Hubert Llewellyn Smith on this point: 'the investigation would not have been possible, for example, without the wealth of detail on the peculiarities of the London boroughs to be found in [Smith's] *New Survey of London Life and Labour*.' Sainsbury, *Suicide in London*, p.7.

London' by taking the 'average number of suicides a year during the five-year period from 1929-1933... obtained from the figures for suicide published by the Registrar-General... and this was divided by the borough population aged fourteen and over in 1931 as given in the census of that year'.[77] He combines these 'rates' with 'social characteristics for which indices were obtained from each borough', namely 'Social and economic status', 'Social isolation', 'Social mobility' and, crucially, '[f]actors presumed indicative of social disorganization. (The incidence of divorce, illegitimacy, and juvenile delinquency were those for which figures were available).'[78] The numbers deployed as indices of these factors are obtained from 'the New Survey of London Life and Labour directed by Sir Hubert Llewellyn Smith... and the Registrar-General's Publications.'[79] This is a large part of Sainsbury's 'immense reservoir' and 'good wicket'. He is able to claim (uncontroversially) that these numbers afford 'an objective body of fact regarding the social conditions that engender suicide'.[80] This is an easy slide between a set of numbers, collected and produced by specific procedures, and a nebulous sense of 'social conditions'. Turning numbers into variables that are supposed to represent 'social disorganisation' is precisely what Herbert Blumer criticises when arguing that such variables are merely 'abbreviated terms of reference'.[81]

In the second part, Sainsbury interrogates coroner data, through access to the records of the Coroner for the Northern District of the County of London. These records include the returns made to the Registrar-General that list the 'place of death' of the person: 'the Registrar-General, in compiling his figures for suicides in the London Boroughs transfers the death to the "fixed or usual residence of the deceased"'.[82] In addition, witnesses are 'given a fairly standardized and detailed interview' by coroners. Thus, not only is 'the verdict of suicide established' but 'pains were taken to find out why the suicide had been resorted to.'[83] All of this demonstrates that when a person is coded as having accomplished their own death, a large number of well-established civil procedures are mobilized to record and reconstruct the act and its surrounding circumstances. These statistical machinations depend upon the judicial machinery of coroners' courts, for a credible 'suicide' object that can be associated with census statistics.

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[77] Sainsbury, *Suicide in London*, p.30.
[78] Ibid., pp.30-31.
[79] Ibid., p.31.
[80] Ibid., p.11.
[81] H. Blumer, "Sociological Analysis and the" Variable"," *American Sociological Review* 21, no.6 (1956): p.689. B. Fincham et al., *Understanding Suicide: A Sociological Autopsy* (Basingstoke: Palgrave Macmillan, 2011), pp.39-40.
[82] Sainsbury, *Suicide in London*, p.31.
[83] Ibid.

Observation wards and interviews

Sainsbury's 'suicide' is a combination of coroners' court proceedings and social indices; 'attempted suicide' in this period is a very different object. In an abstract sense, the objects of 'suicide' and 'attempted suicide' can be connected at a level of competence: somebody wishing to kill themselves might survive by accident or someone attempting to 'cry for help' might die having injured themselves more seriously than intended. Additionally, the different objects of study bear resemblances because of the conceptual languages employed to express them, e.g. statistical 'populations' which Stengel designates the 'language of epidemiology'.[84] Nevertheless, the data through which these objects are constituted are not the same.

Both Hopkins and Stengel (in Liverpool and London observation wards respectively) are aware of some differences. Hopkins, whose study forms part of chapter one, mentions in 1937 that there is 'no one authority to whom all [attempted suicide] cases must be notified'.[85] Stengel, whose 'attempted suicide' combines observation ward records and a number of interviews with patients, friends and relatives,[86] laments of 'attempted suicides' in 1959 that 'there is no machinery for their registration'.[87] Hopkins and Stengel implicitly contrast (observation ward) 'attempted suicide' statistics with those for (coroners') 'completed suicide' – although this contrast is primarily to establish the *inadequacy* of the former, rather than their fundamental difference. (A distinction between the clinical and coroner/social statistics studies is recognised obliquely in Sainsbury's differentiation between 'sociological' and 'psychological' studies.[88])

Stengel is not particularly interested in the conventional coroners' records and social statistics combination, focusing instead upon *clinical work* carried out predominantly within mental observation wards between 1950 and 1953. An appreciation of the difference between the objects of 'suicide' and 'attempted suicide' can help to unpick more problems with the secondary literature on 'attempted suicide'. These problems do not concern the projection of current terminology or redescription, but the easy elision of 'suicide' and 'attempted suicide' statistics.

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[84] E. Stengel, "Some Unexplored Aspects of Suicide and Attempted Suicide," *Comprehensive Psychiatry* 1(1960): p.73. Stengel also says, in 1952: 'Systematic follow-up studies or, to use the modern term, cohort studies'. ———, "Recent Research into Suicide and Attempted Suicide," *American Journal of Psychiatry* 118(1962): p.725.
[85] Hopkins, "Attempted Suicide," p.90.
[86] E. Stengel, N.G. Cook, and I.S. Kreeger, *Attempted Suicide: Its Social Significance and Effects* (London: Chapman & Hall, 1958), p.38.
[87] E. Stengel, "Attempted Suicide and the Law," *Medico-Legal Journal* 27(1959): p.115.
[88] Sainsbury, *Suicide in London*, p.11.

Combining different data: technological determinism and gender roles

Howard Kushner's work on 'attempted suicide' exhibits a critical awareness of the importance of recording practices – principally statistical ones – and yet still proposes a unity (based on 'suicidal method') that is as unexamined and untenable as the 'undercurrent' thesis. Kushner's work deserves close scrutiny here because although he is not concerned with the UK, he makes a sophisticated attempt (from the mid-1980s onwards) to erase the distinction between the 'groups' for a broadly feminist purpose.

Baudelot and Establet's book on suicide is a good example of a work that deploys statistical differences *uncritically*, constituting 'attempted' and 'completed' suicide as separate. It is the kind of work critiqued by Kushner. Baudelot and Establet claim that 'attempted suicide and "successful" suicide are two different phenomena because of the demographic and social characteristics of the individuals involved'.[89] This type of easy reasoning, with no thought for the specifics of statistical practices is taken to task by Kushner, but his analysis becomes confused because of the relationship he posits between 'methods' used and behaviours that are recorded as 'attempted suicide' and 'suicide'. After initial statistical uncertainty, this emphasis on 'methods' is forced to account *entirely* for these different groups.

He is aware that 'some sociologists [claim] that "completers" and "attempters" are substantially distinct from one another',[90] but using the rates from Farberow and Shneidman's North American classic *The Cry for Help* (1961), he asserts that '[i]f the numbers of those attempting and completing suicide are added together, the rate differential between genders collapses.'[91] He argues that 'if we combine completions and attempts, there is not now, nor has there ever been so far as anyone can demonstrate, any gender specific difference in suicidal behavior'.[92] This assertion of parity is curiously undercut in the very next sentence: '[i]n fact, the evidence suggests that women outnumber men in any final tabulation, because attempts are more frequent than completions by as much as eight to one.'[93]

This seeming indecision about whether parity exists or not is mirrored in his discussion of behaviour and method. He claims that 'there seems to be no substantial difference in behaviour between many suicide attempts and those suicides that official statistics report as completions'.[94] Then a couple of lines later he claims that '[i]t may be that men are more often completers of suicide than women because of differences between the sexes in *suicide*

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[89] C. Baudelot and R. Establet, *Suicide: The Hidden Side of Modernity* (Cambridge: Polity, 2008), p.11.
[90] H.I. Kushner, "Women and Suicide in Historical Perspective," Signs 10, no.3 (1985): pp.543-544.
[91] Ibid.: p.543.
[92] Ibid.: p.546.
[93] Ibid.
[94] Ibid.

methods employed.'[95] This might be read as arguing that 'behaviour' and 'method' are unrelated, that one person jumping from a bridge and another shooting themselves are behaving in exactly the same way. It could be – and commonly is – argued that this is the case, as from one vantage point both are simply 'suicidal actions', but this is not Kushner's point.

Instead, 'method' is made to carry the weight of 'gender', and from there he makes an interesting and feminist point. He quotes psychoanalyst Herbert Hendin: '[a]lthough suicide methods influence rates of completion, "there is no relation between particular methods of suicide and suicide intent."' From this, Kushner argues that 'differences in suicide completion rates between men and women are not derived from gender; rather they reflect the methods culturally and historically available to women'.[96] Thus the association between people gendered 'male', and firearms that are considered lethal might be contrasted with sedatives, principally prescribed to those gendered 'female', and considered much less lethal. This is precisely what occurs in Barry Wagner's analysis: '[t]here is some evidence that the sex differences are largely a function of the methods used, that is, males are more likely to use firearms and, therefore, to die, whereas females are more likely to take an overdose and thus to live.'[97]

Thus, it is not that women *intend* to survive (avoiding highly gendered tropes of hysterical or manipulative action) but that the methods available to them are much less lethal, therefore they survive more often. This may be useful politically, as it opens up another method of gender differentiation to historical critique. Kushner makes the feminist point that 'women have had less access to lethal technology than have men. To take this historic pattern as an indication of the emotional needs of women is to perform violence of a different sort.'[98] However, the logical extension of Hendin's point – disassociating 'intent' from 'method used' – assumes that those attempting suicide have no idea about the lethality of the methods that they might employ. This is surely untenable, and in the British context (with which, admittedly, neither Hendin nor Kushner are concerned) the exact opposite is argued by the psychiatrists whose work forms the basis of this study: 'it is common knowledge that you can take a lot of pills, lose consciousness and later return to it none the worse for the experience... some psychiatrists in particular, fail to accept that the information is general.'[99]

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[95] Ibid. Emphasis added.
[96] Ibid.: pp.549, 551.
[97] B.M. Wagner, *Suicidal Behavior in Children and Adolescents* (London: Yale University Press, 2009), p.40.
[98] Kushner, "Women and Suicide," p.551.
[99] N. Kessel, "The Respectability of Self-Poisoning and the Fashion of Survival," *Journal of Psychosomatic Research* 10, no.1 (1966): p.30.

These analyses are problematic because they stumble into a form of technological determinism, where survival or not has more to do with the available 'technologies' for suicide than anything else. To understand gender differences in 'suicidal behaviour' as simply dependent upon access to lethal technology is to misunderstand the power of gender difference. People act in different ways because of the ways in which they understand themselves, not simply because they might find it more difficult to get their hands on a 'lethal' instrument. The above analyses are insufficiently aware of the contextual *meanings* of various actions, subordinating or ignoring them in favour of questions of 'lethality' of method, whilst implying that those 'attempting' in these ways are ignorant of such questions.

Focus upon the availability of technology constitutes significant awareness of the contexts in which human beings might act. However, the above focus upon assessments of *lethality* reduces the context to an overly simplistic level. The position that the technologies available at any given time heavily influence the possibilities for human thought and action is surely not arguable; to reduce human possibilities to these technologies is misguided. It covertly substitutes the historians' or sociologists' assessments of the meaning and potential of these technologies for the assessments of the actors being studied. The idea that taking 20 barbiturate tablets is 'not lethal' is not universal, nor is the idea that a gunshot is highly lethal. To solely blame the ways in which 'allegedly objective social science research is influenced by experts' unconscious biases and unanalyzed assumptions'[100] (as Kushner claims) is to obscure the very real ways in which human beings come to live – and understand themselves and others – through the categories and patterns that are available to them, Hacking's notion of 'making up people'.[101] This study charts the making up of a certain type of 'attempted suicide' in a specific historical context.

John Weaver's *A Sadly Troubled History* (2009) uses suicide records from Queensland and New Zealand, but comes to conclusions remarkably like Kushner's. He claims that 'focus on suicide rates leaves attempted suicide out of the picture. Women have led men in parasuicide.'[102] Why this should be is not broached, but he is in almost complete agreement with Kushner's argument: 'roughly speaking, the gender ratios of suicide and parasuicide are reciprocal'.[103] He does not take the final step of assuming a sense of parity 'underneath' the 'bias', instead quoting a study which concludes that 'the male gender role... prevents males from "cry-for-

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[100] Kushner, "Women and Suicide," p.551-552.
[101] I. Hacking, "Making up People," in *Beyond the Body Proper: Reading the Anthropology of Material Life*, ed. M. Lock and J. Farquhar (Durham, NC: Duke University Press, 2007).
[102] J.C. Weaver, *A Sadly Troubled History: The Meanings of Suicide in the Modern Age* (Ithaca: McGill-Queen's University Press, 2009), p.214.
[103] Ibid., p.300.

help" parasuicides.'[104] Concern with 'gender roles' is important, but is used by Weaver much like Kushner uses 'technology of method' – to explain the differences that emerge from statistical analyses.

Neither study focuses upon how their statistics are dependent upon the practices that collect and assemble them. To combine two very different statistical objects (by asserting that they are reciprocal), and then differentiate them on the basis of a simplistic 'gender role' or 'technology' argument, fails to appreciate how the *combination* of these different statistics does not correspond unproblematically or self-evidently to the overarching abstraction 'suicidal behaviour'. The attempt to 'correct' statistics that are 'wrong' is based upon this homogenised composite, 'suicidal behaviour'.

Finally, a 1967 study of 'completed suicide' does focus upon the context-specific meanings of behaviours. Jack D. Douglas' *The Social Meanings of Suicide* argues that '[t]hroughout the Western world today there exists a general belief that one knows something only when it has been counted. Enumeration has become the cornerstone of knowledge'.[105] This being the case, 'it is a remarkable fact that there is at present very little systematic knowledge of the function of official statistics-keeping organizations.'[106] He highlights the importance of the context of any information about any given phenomenon, noting that 'Halbwachs long ago pointed out that Durkheim's formal definition of suicide is of no relevance to Durkheim's theory of suicide because the data used to test the theory of suicide were not collected with this definition in mind.'[107] Thus Douglas explicitly *refuses* to project meanings from one context (a coroner's assessment of whether or not a death counts as a 'suicide') to another (Durkheim's definition of suicide). His aim is to bring out 'the *essentially problematic nature* of such social meanings [which] means that the idea of a "real rate" is a misconception. How many "suicides" there are in a given group at a given time is dependent upon the concrete argument processes used.'[108] Thus the entire phenomenon of suicide depends upon contextually specific methods of sense-making, what Douglas calls 'concrete argument processes'.

Douglas' concern for contingent, contextually established meaning (drawing upon the work of Max Weber[109]) has important resonances with this study. However, his attempts to open up suicide statistics to critique involve taking case studies directly from Stengel's *Attempted*

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[104] Ibid., p.297. See also S.S. Canetto, "Men Who Survive a Suicidal Act: Successful Coping or Failed Masculinity?," in *Men's Health and Illness: Gender, Power and the Body*, ed. D. Sabo and D.F. Gordon (Thousand Oaks: Sage, 1995), p.292.
[105] Douglas, *Social Meanings*, p.163.
[106] Ibid.
[107] Ibid., p.169.
[108] Ibid., p.231. Original emphasis.
[109] Ibid., p.235.

Suicide[110] in order to show that the meanings of suicidal phenomena are unstable and specific to individuals and their contexts. He is aware that 'some of the more recent [studies] have used visits by psychiatric workers to the homes of the suicides or attempted suicides to get more and better information on the cases.'[111] Instead of seeing this specific practice as simply providing 'more and better information', the present thesis investigates how such practices as home-visiting become consistently applied to people read as having 'attempted suicide', and how different professionals come into consistent contact with new types of patient, establishing new fields for psychological scrutiny, where new psychological objects might be constituted.

The above approaches to 'attempted suicide' fail to appreciate that these objects have no existence beyond their contexts. Their inconsistencies can be avoided by using Michel Foucault's strategies for analysing the changing, historically specific technologies that produce 'objective facts' about the world. He claims that through analysis of these technologies, these practices, it 'can be seen both what was constituted as real for those who sought to think it and manage it and the way in which the latter constituted themselves as subjects capable of knowing, analyzing, and ultimately altering reality.'[112] A close analysis of the practices and contexts through which 'attempted suicide' could function, at a certain time, in certain places, as an idea, a diagnosis, an epidemic or a performance is central. There is no attempt here to find the 'real meaning' or some unchanging 'emotional response' that is expressed through changing cultures. Only by appreciating the fundamentally *historical* character of sense-making can a narrative be formed without the stifling teleology of presentism.

Having argued for the centrality of context, it is important to sketch out two specific contexts that will be drawn in increasing detail throughout. General medicine and psychiatric expertise are persistently separate throughout this period, but the ways in which these approaches are practically and institutionally separated undergoes radical change. The second context concerns social psychiatry. This particular conception of mental disorder, and the importance of social relationships in the aetiology of psychic disturbances, is a vital part of the credibility of an epidemic of 'attempted suicide a cry for help'. A huge amount of intellectual and practical labour is invested in accessing the 'social settings' of people brought under psychiatric scrutiny. This is the same social setting with which the 'attempted suicide' is said to be communicating.

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[110] Ibid., pp.277-278.
[111] Ibid., p.164.
[112] M. Foucault, *The Essential Works of Michel Foucault, 1954-1984. Vol. 2, Aesthetics* (London: Penguin, 2000), p.463.

Separated therapeutic approaches

According to standard narratives 'mental medicine' is largely separate from other branches through the geographically remote lunatic asylum from the mid-nineteenth century in Britain.[113] This insulation of psychiatric from general medicine is a key area in which change is sought during the twentieth century.[114] A divide endures: the government's *National Service Framework for Mental Health* (1999) recommends that mental healthcare be provided by 'single-speciality mental health trusts' in urbanised areas, proposing a sharp administrative division between psychological and general medicine. Two liaison (general hospital) psychiatrists argue in 2003 that 'these mental health trusts threaten to repeat the mistakes of their 19th-century predecessors' by perpetuating the stigma of mental illness, and undermining the view that 'the distinction between physical and mental illness is conceptually flawed.'[115] Regardless, single-speciality trusts are again championed in a 2007 Department of Health Annual Report.[116] The mid-twentieth-century history of this divide runs through three Acts of Parliament. The Mental Treatment Act 1930 allows non-certified treatment in county asylums; the establishment of the NHS (1948) brings mental and general medicine under the same administrative structure; the Mental Health Act 1959 removes all legal barriers to the treatment of mental illness in general hospitals. These developments are written into a smooth narrative of progressive integration, with 1959 as the culmination of the process.[117]

This progression is simplistic, flattening the three decades between 1930 and 1960 into a smooth road away from legal constraint, the stigma of separation, and from asylums themselves in a process known as 'deinstitutionalisation'.[118] Efforts to integrate the separated therapeutics of mental and general medicine form a crucial backdrop throughout this thesis, but instead of being smooth or teleological, this process is uneven, faltering and local. This separation of 'mental' from 'general' medicine is not inevitable, or rooted in some deep-seated consistent Cartesian organising principle. It the result of a number of complicated historical developments, and sustained by specific practical and institutional arrangements.

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[113] For example R. Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London: Fontana Press, 1999), pp.493-494.

[114] It is important to highlight that this division is not coterminous with a 'mental' 'physical' binary, as many of the treatments for the 'mentally ill' are somatic in this period (and remain so today), from bromides to leucotomy to electro-convulsive therapy.

[115] G.G. Lloyd and R.A. Mayou, "Liaison Psychiatry or Psychological Medicine?," *The British Journal of Psychiatry* 183, no.1 (2003): p.5.

[116] Department of Health 'The configuration of mental health services' (2007) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4897913 accessed 13.07.2012.

[117] See W.S. Maclay, "After the Mental Health Act: An Appraisal of English Psychiatry," *Mental Hospitals* 14(1963): p.100.

[118] See e.g. P. Barham, *Closing the Asylum: The Mental Patient in Modern Society* (Harmondsworth: Penguin, 1992); P. Brown, *The Transfer of Care: Psychiatric Deinstitutionalization and Its Aftermath* (Boston: Routledge & Kegan Paul, 1985).

As psychological scrutiny becomes entrenched in general hospitals, the division is rearticulated by the traffic across it. This hospital-based traffic constitutes the core of 'attempted suicide as a cry for help' throughout the period. The shifting and specific arrangements that effect this traffic are described sequentially throughout the thesis. It is worth reiterating here that these divisions are not self-evident, natural or inevitable; this will become clear as each arrangement is discussed in turn. This argumentative focus cuts across the standard asylum-to-community narratives in the history of twentieth-century psychiatry. Too close a focus on the well-tilled ground of 1959 obscures the significance of developments in general hospital mental observation wards that significantly foreshadow the late 1950s attempts to combine psychological and general medical expertise.

During the early 1960s, studies emerge from different places (including London, Edinburgh, Birmingham and Sheffield) establishing 'attempted suicide' as an epidemic phenomenon. This is principally because the opportunities for psychological scrutiny of patients presenting at hospitals with 'physical injuries' is *increased* by the changes and trends made explicit and further enabled in the Mental Health Act. 'Attempted suicide' becomes a new object of study through a *transformation of physical injury into a psychosocial disturbance*. That is, the injury that provokes admission to hospital is subordinated to a pathological social situation or psychological state. Patients arrive at hospital casualty departments, the most non-specialised part of the hospital system, due to a *physical injury*. After this has been assessed for its urgency, the patient might be treated with stitches or stomach-washing within the department, or transferred for resuscitation or surgery. It is only *after* this physical injury has been dealt with that the patient is investigated from a social-psychiatric point of view, and this is increasingly carried out by different medical professionals. Patients must consistently be *referred* for psychological scrutiny if the 'cry for help' is to emerge on any significant scale. This transformation thus rests upon two innovations: consistently applied arrangements focussing psychological scrutiny upon patients presenting with a physical injury at a general hospital, and the resources for *intense* scrutiny and social follow-up, to fabricate a credible 'social constellation' to which the 'attempted suicide' is supposed to be appealing. (The strong differentiation between 'physical' and 'psychological' used to clarify the 'transformation' might be unclear, unimportant or ambivalent for the patients, or anyone else who helps effect their removal to a hospital.)

Relating a physical injury to a social, domestic, romantic or familial context is time-consuming and labour intensive, requiring interviews, questionnaires, social workers, follow-up and home visiting. The injury is not just contextualised, it is fundamentally *recast as a symptom* of this 'social constellation.' A specifically 'domestic' social context is constructed in various credible

ways, by a newly influential profession of psychiatric social workers (PSWs). It is through consistent psychological scrutiny around general hospitals that 'attempted suicide' emerges. It is through this scrutiny that suicidal intent is made complex and ambiguous, in a consistent and stable way. The possibility for an epidemic of 'attempted suicide' is, in this sense, fundamentally contextual and historical. It is constituted and sustained by various possibilities for different kinds of scrutiny within a specific healthcare system. Changes in hospital organisation, mental healthcare provision, medical research and the law are all implicated in the emergence of 'attempted suicide' as an 'object for study', especially the new potential crossovers between psychological and general medical care at general hospitals.

'Stress', social psychiatry and psychiatric epidemiology

Just as the administrative separation of (and referral between) general and psychiatric medicine is important in the constitution of this 'attempted suicide', the *type* of psychiatric scrutiny focused upon the cases so referred is also important. 'Attempted suicide' emerges through psychiatric epidemiology. This branch of psychiatry associates mental disorder with certain features of the environment, in this case, the social environment. It is significant (and unsurprising) that a branch of mental medicine so concerned with social spaces and relationships interprets certain 'self-inflicted injuries' as *communications* with that social environment. (It is important not to confuse the specialised, environment-focused usage of 'epidemiology' with the common usage of 'epidemic' meaning simply a high number of people affected.)

Ideas of 'stress' and 'coping' are integral to social psychiatry and psychiatric epidemiology in Britain. Mental disorder is embedded in social relationships and situations through notions of 'stress', which have a long history. In 1959 George Rosen concludes that '[f]rom the 18th century to the present there has existed the concept that social stress is in some way related to the causation of mental illness.'[119] Rhodri Hayward argues that whilst 'folk association[s]' between 'personal adversity' and 'physical distress… may seem long lasting, its component elements… have repeatedly been reconstituted around different sets of goals and using different investigative technologies.'[120] The relationship between 'investigative technologies' and models of 'distress' is crucial. Joan Busfield argues that 'part of the attraction of stress is the easy way in which a diversity of experiences… can be brought into the fold… the concept

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[119] G. Rosen, "Social Stress and Mental Disease from the Eighteenth Century to the Present: Some Origins of Social Psychiatry," *Milbank Memorial Fund Quarterly* 37, no.1 (1959): p.28.
[120] R. Hayward, "Sadness in Camberwell: Imagining Stress and Constructing History in Post War Britain [Draft]," (Washington D.C.2010), p.1.

can be used to link features of the individual's *social* environment to mental disorder.'[121] The history of psychology traces 'stress' back through the work of Hans Selye (1907-1982), whose General Adaptation Syndrome (GAS) is based upon endocrinological experiments with mice,[122] and Walter Canon (1871-1945), whose first famous experiments are with dogs (he later coins the phrase 'fight or flight' to describe responses to stress and establishes the concept of 'homeostasis').[123] It is claimed that Selye 'redefined the word, stress… as being (or a state resulting in) the "the nonspecific response of the body to any demand upon it" [which] was so persuasive that it persisted and remains widely used today.'[124]

These laboratory experiments are claimed to lead back to 'the chrysalis of psychobiology generated by Adolf Meyer [1866-1950] through his invention and use of the "life chart"'.[125] The influence of Meyer upon D.K. Henderson and R.D. Gillespie among many other British psychiatrists is broached below. 'Stress' gains prominence during the late 1960s and 1970s through psychological rating scales, especially the US-based work of personality theorist Raymond B. Cattell, and Thomas Holmes and Richard Rahe's Social Readjustment Scale and Schedule of Recent Experience (1967).[126] In Britain, anthropologist George Brown and social psychiatrist Tirril Harris construct the Bedford College Life Events and Difficulties Scale in the 1970s.[127] Perhaps the most influential twentieth-century articulation of stress is found in Post-Traumatic Stress Disorder (PTSD), the genesis of which Allan Young has meticulously charted through Veterans' Administration hospitals in the aftermath of the American war in Vietnam.[128] Hayward argues that it is 'now a commonplace among psychiatrists, sociologists and historians to bemoan the ill-defined nature of stress and the theoretical fecundity that this sustains.'[129] Precisely this 'fecundity' is the focus here, for 'stress' is much broader than this particular historical thread. It is a key intellectual plank for the projects of social psychiatry and psychiatric epidemiology, through the links it makes possible between environment and

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[121] J. Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder* (Basingstoke: Macmillan, 1996), p.190. Original emphasis.

[122] H. Selye, *Stress of Life* (London: McGraw-Hill, 1956).

[123] W.B. Cannon, *Bodily Changes in Pain, Hunger, Fear and Rage* (New York: D. Appleton & Co., 1929); ———, "Organization for Physiological Homeostasis," *Physiological Reviews* 9(1929).

[124] D.S. Goldstein and I.J. Kopin, "Evolution of Concepts of Stress," *Stress: The International Journal on the Biology of Stress* 10, no.2 (2007): p.110.

[125] Holmes & Masuda quoted in C.L. Cooper and P. Dewe, *Stress: A Brief History* (Oxford: Blackwell, 2004), p.42.

[126] T.H Holmes and R.H. Rahe, "The Social Readjustment Rating Scale," *Journal of Psychosomatic Research* 11, no.2 (1967). See also G.A. Foulds et al., *Personality and Personal Illness* (London: Tavistock Publications, 1965).

[127] G.W. Brown and T. Harris, *Social Origins of Depression : A Study of Psychiatric Disorder in Women* (London: Tavistock Publications, 1978).

[128] Young, *Harmony of Illusions*.

[129] Hayward, "Sadness in Camberwell [Draft]," p.2. Regarding 'attempted suicide', Jack quotes Cloward and Piven's remark that '[s]tress is being made to explain too much'. Jack, *Women and Attempted Suicide*, p.23.

mental disorder. It functions as a versatile blanket category and explanation, and is used most prominently (in 'cry for help' studies) by Neil Kessel in his work on 'self-poisoning' in Edinburgh during the early 1960s.[130]

The necessity for a new 'model' to guarantee *psychiatric* epidemiology is clear in light of 'traditional' epidemiological concerns. Up until the Second World War, this approach makes most sense in the quest to control and prevent infectious diseases such as typhoid, cholera and influenza. However, Joseph Goldberger's 'impeccable studies of pellagra'[131] at the turn of the twentieth century in the American South show that the diseases do not have to be infectious; pellagra is found to be associated with various deficiencies in diet. David Armstrong quotes hospital statistician D. Mackay, who notes in 1951 that if 'the search for specific (aetiological) agents halted the presence of social medicine then the role of nutrition, psychological medicine, stress and other trends reawakened interests in "broader domains of aetiology"'.[132] This is the broad background category of 'social psychiatry'. Nutrition is a reference to the pellagra studies, and psychological medicine and stress do a similar job, bridging the gap seen as the essence of epidemiology: relating 'findings in the "cases" … to the defined population in which those cases arose'.[133]

After 1945, epidemiological methods are increasingly applied in psychology. Mark Parascandola argues that 'by the 1950s epidemiologic methods and thinking had expanded beyond the mere study of epidemics to human experiments testing preventative interventions, case-control observations in hospital patients, and the long-term study of generally healthy cohorts.'[134] The 'epidemiology of mental disorders' begins to make sense – as the distribution of mental problems within a defined area. However, this is 'a difficult transition that still troubles epidemiology',[135] exemplified by the reaction of a Professor of Bacteriology in 1952, who is furious at

> 'an undoubted debauchery of a precise and essential word, "epidemiology" which
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> is being inflated by writers on social medicine and similar subjects to include the
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> study of the frequency or incidence of diseases whether epidemic or not... an

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[130] See chapter four.

[131] M. Shepherd, "Prologue: A Critical Appraisal of Contemporary Psychiatry," in *The Psychosocial Matrix of Psychiatry: Collected Papers*, ed. Michael Shepherd (London: Tavistock, 1983), p.20.

[132] D. Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge: C.U.P., 1983), p.100. quoting D. MacKay *Hospital Morbidity Statistics*. Studies on Medical and Population Subjects no.4 (1951).

[133] G. Rose and D.J.P. Barker, "What Is Epidemiology?," *British Medical Journal* 2(1978): p.803.

[134] M. Parascandola, "Epidemiology in Transition: Tobacco and Lung Cancer in the 1950s," in *Body Counts: Medical Quantification in Historical and Sociological Perspective*, ed. G. Jorland, A. Opinel, and G. Weisz (Ithaca: McGill-Queen's University Press, 2005), p.226.

[135] Ibid., p.227.

epidemic is disease prevalent among a people or a community at a special time, and produced by some special causes not generally present in the affected locality. Therefore, to speak of the epidemiology of coronary thrombosis, or of hare lip, or diabetes, or of any non-epidemic disease, is a debasement of the currency of thought. It is of no use saying that the word is being used in its wider sense. It has no wider sense.'[136]

Michael Shepherd – the first ever Professor of Epidemiological Psychiatry[137] – points out that this is by no means a modern 'inflation' of the term. He cites J.C.F. Hecker's *The Epidemics of the Middle Ages* (1859), which, in addition to surveying the Black Death and the Sweating Sickness, also deals with an epidemic of 'disordered behaviour, the Dancing Mania [and] makes no distinction between epidemics of infectious disease and those of morbid behaviour'.[138] Richard de Alarcón recycles Jerry Morris' 1957 observation that '[t]here are many interesting analogies between the dynamics of infectious disease and that of mental illness: from the dancing mania of the Middle Ages to epidemic benzedrine addiction.'[139] However, even psychiatrist and anthropologist G.M. Carstairs, head of a research unit on the 'Epidemiology of Mental Disorders' is uneasy about the meaning of the word in 1959, noting that 'I find that this term "Epidemiology" is in the process of acquiring a new, specialised meaning which is at a variance with its generally accepted one: the study of epidemics. As a result I find that even with medical men the term "epidemiology of mental disorders" usually requires some explanation'.[140]

Carstairs glosses the history of psychiatric epidemiology in his 1959 application to head this research unit. Two key events are the 1949 Annual conference of the Milbank Memorial Fund in New York[141] and a 'review by Eric Strömgren: "Statistical and Genetical Studies within Psychiatry"' from 1950.[142] He also mentions 'an international working party on research method in psychiatric epidemiology... in London in September, 1958, in order to discuss, amend, and finally endorse a "canon" of research methodology prepared for this meeting by Dr. D.D. Reid',[143] an epidemiologist who investigates 'flying stress' during the Second World

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[136] A.D. Gardner, "Debauchery of Honest Words," *British Medical Journal* 1, no.4760 (1952): p.715.

[137] A. Clare, "Obituary: Professor Michael Shepherd," *Independent*, 30.08.1995.

[138] M. Shepherd, "Epidemiology and Clinical Psychaitry," *British Journal of Psychiatry* 133(1978): p.289.

[139] R. de Alarcón, "The Spread of Heroin Abuse in a Community," *Bulletin on Narcotics (United Nations)* 21, no.3 (1969): p.21.

[140] Letter from G.M. Carstairs to H. Himsworth (MRC Secretary) dated 01.07.1959, TNA: PRO FD 7/1043.

[141] G.M. Carstairs, 'Memorandum to Council and CRB': 'Proposed Unit for Research on the Epidemiology of Mental Disorders' p.1 , TNA: PRO FD 7/1043.

[142] Ibid.

[143] Ibid.

War.[144] His 'canonical' document is published as the WHO report *Epidemiological Methods in the Study of Mental Disorders* (1960).[145] Morris' 'interesting analogies' and Shepherd's 'inflation' nimbly sidestep serious conceptual issues, specifically the lack of a single agreed model to relate mental disorder to *groups* of human beings, rather than individuals.

One of the models undergirding *nineteenth*-century social medicine is the concept of 'miasma'. Nikolas Rose describes a spatial conception of pathology growing out of 'complex regimes of medical practice [that] spread across urban space.[146] These 'complex regimes' in general (rather than psychological) medicine are undergirded by 'miasma', which 'lent itself to a medicine of social spaces: diseases were produced in certain types of social space.'[147] Psychiatric epidemiology and social psychiatry begin to make sense in the twentieth century because of an idea as all-encompassing as 'miasma': a broad and eclectic set of explanations under the terms 'stress' and 'distress'. These are neither normal nor pathological, but the very fabric of social psychology, and negotiating the borderline between mental health and mental illness. In the twentieth century, 'the social' is rearticulated through 'stress', 'distress' and 'coping' in new and pervasive ways as a source and broad canvas for psychological problems, so that by the early 1950s 'the psychiatrist… is incessantly forced to consider the social relations of his patient.'[148] David Armstrong's *The Political Anatomy of the Body* (1983) contains perhaps the most compelling and wide-ranging demonstration of this in a British context. Armstrong's argument is structured by a shift from 'panoptic' to 'Dispensary' medicine:

> 'the panoptic vision created individual bodies by objectifying them through their analysis and description… [t]he new body is not a disciplined object constituted by a medical gaze which traverses it, but a body fabricated by a gaze which surrounds it… *a body constituted by its social relationships* and relative mental functioning'[149]

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[144] H.B., "Obituary: D.D.Reid," *British Medical Journal* 1, no.6066 (1977): p.981.

[145] Reid acknowledges 'the informed and helpful suggestions made by the members of the Joint Technical Meeting on Epidemiological Method in Psychiatry held in London in September 1958.' D.D. Reid, *Epidemiological Methods in the Study of Mental Disorders* (Geneva: World Health Organization, 1960), p.7.

[146] N. Rose, "Medicine, History and the Present," in *Reassessing Foucault: Power, Medicine and the Body*, ed. C.D.H. Jones and R. Porter (London: Routledge, 1994), p.63.

[147] Ibid., p.56.

[148] A. Lewis, "Social Aspects of Psychiatry: Part I," *Edinburgh medical journal* 58, no.5 (1951): p.215.

[149] Armstrong, *Political Anatomy*, p.102. Emphasis added.

The 'Dispensary' is Armstrong's name for this 'new gaze [which] identified disease in the spaces between people, in the interstices of relationships, in the social body itself'.[150] The whole set of moves towards 'decarceration' 'community care' in psychiatry are reduced, in Armstrong's analysis, to expressions of power relations: '[c]omprehensive healthcare in Britain, from 1948, and the contemporary invention and importance placed on community care are simply manifestations of a new diagram of power'.[151] One consequence of this reduction is that the 'social gaze' appears as almost totally novel, the result of a radical rupture. If Armstrong overemphasises novelty, then Barbara Taylor possibly goes too far the other way, viewing these post-1945 developments towards 'community' more simply as a 'revitalisation of moral therapy' or a 'moral-treatment renaissance'.[152] Emphasis on the similarity between nineteenth-century 'moral treatment' and twentieth-century 'social psychiatry' obscures important differences between them, not least that the former is largely practiced inside asylums, whereas social psychiatry has a quite different view of the 'community'. Whatever the links to earlier ideas, social medicine in the second half of the twentieth century in Britain is articulated in a social field populated by the psychological objects of 'stress' and 'distress'.

The link between 'stress' and this idea of 'the social' is made clear by Armstrong: '[i]n psychiatry, sociology has provided a rich and diverse contribution to the extension of the medical gaze… theoretically it, together with psychology, has helped to define *basic concepts, such as stress and coping*… In short, sociology has reinforced the shift of the psychiatric gaze'.[153] In this social, relational environment, Armstrong notes that

> 'a vast literature on "stress" emerged in the post-war years. Patients would define
> their own limits and make their own decisions: "when a patient calls on his doctor
> for help he generally implies that his own efforts are not enough".'[154]

This 'calling on the doctor for help' explicitly shows how social ideas of 'stress and coping' can feed into 'communicative action'. For it is 'social stress' that prompts the 'communication', but also, the social environment is where help is sought, through communication. 'Stress' is what enables mental illness and environment to be mutually reconstituted. To conceptualise a

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[150] Ibid., p.8. The term derives from an Edinburgh tuberculosis dispensary in 1887. Armstrong sees this as an archetype of a new kind of community medicine (which also includes social psychiatry and epidemiology).

[151] He continues: 'The community was the term deployed to describe that truly social space that had emerged in the calculated gap between bodies'. Armstrong, *Political Anatomy*, p.100.

[152] B. Taylor, "The Demise of the Asylum in Late Twentieth-Century Britain: A Personal History," *Transactions of the Royal Historical Society (Sixth Series)* 21, no.1 (2011): p.209.

[153] Armstrong, *Political Anatomy*, p.114. Emphasis added.

[154] Ibid., p.72. quoting H. Merskey and W.L. Tonge, *Psychiatric Illness. Diagnosis and Management for General Practitioners and Students* (London: Baillière, Tindall & Cox, 1965), p.6.

patient calling upon a doctor for help as 'at the limit of their resources' is to fabricate these very resources as part of the social field. In 1965 Neil Kessel expresses 'self poisoning' in the language of 'limits' and 'coping': '[n]obody takes poison, a little or a lot, to live or to die, unless at that moment he is distressed beyond what he can bear'.[155] The idea that communication is central to mental illness is widespread in psychiatric thought after the Second World War. In fact, this idea becomes central to so-called 'anti-psychiatry' as much as mainstream psychiatric thought.

In Jurgen Ruesch and Gregory Bateson's *Communication: The Social Matrix of Psychiatry* (1951), Ruesch touches upon the practical shifts mentioned above, noting that '[p]sychiatrists have moved out of the enclosing walls of mental institutions and have found a new field of activity in the general hospitals of the community and in private practice.' Importantly, this leads to the argument that 'it is necessary to see the individual in the context of his social situation.'[156] In fact he goes even further, claiming that it is 'the task of psychiatry to help those who have failed to experience successful communication' and that '[p]sychopathology is defined in terms of disturbances of communication.'[157] Ruesch admits that such a formulation might be a little surprising, but that the sceptical reader need only open a textbook of psychiatry to find that terms such as 'illusions', 'delusions', 'dissociation' or 'withdrawal' in fact 'refer specifically to disturbances of communication'.[158]

A decade later, Thomas Szasz's *The Myth of Mental Illness* (1961) casts 'hysteria' as an archetype for psychiatric practice, an 'historical paradigm of the sorts of phenomena to which the term "mental illness" refers.'[159] In other words, 'hysteria' is not only an excellent example, but *the definitive* example. One of the pivotal chapters in this foundational text of anti-psychiatry is 'Hysteria as communication'.[160] Similar to Olive Anderson's comments about distinguishing 'sham' from 'real' in Victorian attempted suicide, Szasz argues that hysteria 'presents the physician with the task to distinguishing the "real" or genuine from the "unreal" or false.'[161] This also links up to Derrick Dunlop's (1967) and Raymond Jack's (1992) associations of 'self-poisoning' with 'hysteria'. Ideas around communication are absolutely central to psychiatric thought during the post-War period, even whilst they are anchored in, and stabilised by, much older concerns.

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[155] N. Kessel, "Self-Poisoning (2)," *British Medical Journal* 2, no.5474 (1965): p.1336.

[156] J. Ruesch and G. Bateson, *Communication: The Social Matrix of Psychiatry* (New York: W.W. Norton, 1951), p.3.

[157] Ibid., pp.50, 78.

[158] Ibid., p.79.

[159] T.S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (London: Paladin, [1961] 1972), p.25.

[160] Ibid., pp.128-152.

[161] Ibid., p.25.

These ideas have not gone away. For Mikkel Borch-Jacobsen, writing in 2001, communication is still central to all psychiatric illness, arguing that' [h]owever aberrant or incomprehensible they might appear at first glance, the patient's symptoms are always distress signals, calls for help'.[162] 'Communication' and the 'social environment' are not only mutually reinforcing, *they are part of the same idea*: the social environment cannot exist without meaningful information passing between humans, just as communication requires more than one self-contained individual. They are both absolutely central to the rearticulation and wide resonance of 'attempted suicide as a cry for help'. The emergence of social psychiatry, undergirded by the analytical tools of 'coping' and 'stress' casts mental illness as a form of communication: 'attempted suicide as cry for help' is an expression of, and a driving force behind, this turn to the social.

Textbook Emergence

Having argued thus far that the object 'attempted suicide' is *not* eternal, ever-present, or rooted in an unbroken undercurrent of emotional response, it is necessary to demonstrate its specific emergence with some precision. This can be achieved through analysis of successive editions of two popular British psychiatric textbooks.

The *Textbook of Psychiatry* written by David Kennedy Henderson and Robert Dick Gillespie gains 'an international reputation, known simply as Henderson and Gillespie' over ten editions and forty-two years between 1927 and 1969.[163] Maxwell Jones remembers Henderson as 'the great high priest of psychiatry' at Edinburgh in the early twentieth century,[164] while Gillespie is a brilliant but ultimately tragic figure who commits suicide in 1945.[165] Willy Mayer-Gross, Elliot Slater and Martin Roth's *Clinical Psychiatry* is also a 'standard textbook' over three editions between 1954 and 1969.[166] It is written, according to Slater, because '[t]he textbooks available at that time were either not very comprehensive or not all that good. The American ones were mainly full of Freud, or Adolf Meyer's psychobiology. Henderson and Gillespie was rather an old-stager.'[167] The emergent phenomenon of 'attempted suicide as cry for help' can be tracked, and its underpinnings glimpsed, through the editions of these texts, which are written

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[162] M. Borch-Jacobsen, "Making Psychiatric History: Madness as Folie À Plusieurs," *History of the Human Sciences* 14, no.2 (2001): p.26.

[163] K. Loughlin, "Henderson, Sir David Kennedy (1884–1965)," in *Oxford Dictionary of National Biography* (Oxford: O.U.P., 2004).

[164] M. Jones in Wilkinson, *Talking*, p.51.

[165] B. Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, MA: Harvard University Press, 2001), p.297. Shepherd's information on this point is an interview with Henry Rollin; there appears to be no other reference in print.

[166] E. Paykel, "Sir Martin Roth," *Psychiatric Bulletin* 31, no.5 (2007): p.195.

[167] Wilkinson, *Talking*, p.8.

as aids for trainee psychiatrists and general practitioners, as well as reference works for specialists.

In Henderson and Gillespie, the principal references to suicide and suicidal behaviour in the first five editions (1927-1940) concern the need for vigilance when caring for patients diagnosed with conditions such as 'depression' or 'involutional melancholia': '[t]he most important feature of depression in general, from the point of view of care and treatment, is the danger of suicide.'[168] Suicide appears here as one possible *outcome* of psychiatric illness, a potential 'final symptom' of sorts. They argue that '[t]he rôle of alcohol has been much exaggerated' in the aetiology 'of certifiable cases of mental disorder,'[169] but note that a 'considerable proportion of attempted suicides' are 'due to alcohol'.[170] These statements are reproduced throughout the five editions up until 1940, with no effort to establish any differences of *intent* between people who 'succeed' in their attempts and those who 'fail'.

The preface to the 1944 edition notes that the 'remarkable progress that has occurred in psychiatry in recent years in the teeth of war conditions, and even to a limited extent because of them' which necessitates 'much new material'.[171] This marks 'a new epoch in medicine and emphasises what psychiatry has for so long been doing – treating the individual in his social setting and making allowance for psychological as well as physical factors.'[172] Under the subheading 'Depression' in the chapter on 'Manic-Depressive Psychoses' there is this new material: '[w]e have been impressed by the large proportion of cases of attempted suicide admitted to the Royal Infirmary, Edinburgh, and Guy's Hospital, London, who have never previously seemed to require psychiatric guidance or control. The rapidity with which recovery occurs is also a factor to be noted and is in striking contrast to the prolonged treatment of the average case of depression.'[173] This emergent object is tentatively cast as a new (short-term) form of 'depression', appearing under wartime conditions.

This new object is distinctive, according to Henderson and Gillespie because of the lack of previous psychiatric contact with the patients.[174] Indeed, naming the hospital clinics serves to clarify that these 'attempted suicides' are not first seen at psychiatric hospitals. They are also 'struck by the trivial nature of the precipitating factors in some cases.' For example

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[168] D.K. Henderson and R.D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners*, 1st ed. (London: Humphrey Milford, 1927), p.133.
[169] Ibid., p.145.
[170] Ibid.
[171] ———, *A Text-Book of Psychiatry for Students and Practitioners*, 6th ed. (Oxford: O.U.P., 1944), p.vii.
[172] Ibid., p.12.
[173] Ibid., p.238.
[174] This point is emphasised further: 'Such people are no doubt in some ways psychopathic, but not always in ways that brings them to notice before the suicidal attempt itself.' Ibid.

'a husband requested by his wife to sleep for the time being in an attic to make room for a guest; a girl who had been "walking-out" with a soldier of whom her father disapproved, so that being afraid to return home she walked into the Thames, near London Bridge, instead.'[175]

An 'attempted suicide' and bafflingly 'trivial' interpersonal conflicts become visible at certain general hospitals. An element of communication is also noted in some cases, but this does not map neatly onto the division between those who survive the 'attempt' and those who do not: '[s]ometimes spite enters as a basis for the suicidal gesture, but it is a gesture which is sometimes carried to the point of successful self-destruction.'[176] These changes are linked on an intellectual level to the commitment to 'treat the individual in his social setting', which can potentially bring to light such conflicts, but it is also down to the availability of informal psychiatric scrutiny in a clinic, outside of a mental hospital (see chapters two and three). The sixth, seventh and eighth editions (1944, 1950, 1956), see radical changes in the authorship of the textbook, after Gillespie's suicide. Henderson edits the 1950 version alone, and brings in Ivor R.C. Batchelor to assist with the 1956 edition. Despite these changes (and the fact that Batchelor publishes a number of articles on the subject between 1952 and 1955[177]), the above text concerning 'attempted suicide' remains the same.

In the 1962 (ninth) edition, 'suicide' and 'attempted suicide' are clearly separated: '[a]ttempted suicide is much commoner than suicide in Western communities: how much commoner we do not know since many cases are neither reported to the police nor even admitted to hospital.'[178] The idea that 'attempted suicide' is separate from, more common, and less likely to be registered than 'completed suicide' are key characteristics of the clinical object. Under the heading 'suicidal acts' it is raised to the status of 'a social phenomenon of great importance and a concern not only to psychiatrists but to society as a whole.'[179] They refer to Stengel's work on 'the social aspects of suicidal attempts' which leads to the suggestion that 'those who attempt and those who commit suicide constitute two different populations'.[180] They note that Stengel's differentiation has an important gendered dimension: 'the majority of those who commit suicide are males while the majority of those who attempt it are females'.[181] Henderson and Batchelor are not convinced that the populations are

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[175] Ibid.
[176] Ibid.
[177] See chapter two.
[178] D.K. Henderson and I.R.C. Batchelor, *Henderson and Gillespie's Textbook of Psychiatry*, 9th ed. (London: O.U.P., 1962), p.73.
[179] Ibid., p.71.
[180] Ibid., p.73.
[181] Ibid.

completely separate: 'the two populations overlap, and it would not accord with the facts, but lead in practice to an underestimation of the risks to life inherent in suicidal attempts, to draw any sharp distinctions between attempted suicide and suicide itself... No firm line can be drawn between suicidal gestures and suicidal attempts'.[182]Nevertheless, they are broadly supportive of Stengel's project, arguing that 'emphasis on the appeal function of suicidal attempts and on the participation of the patient's group very properly draws attention to social aspects of individual suicidal acts'.[183]

The final (tenth) edition is published in 1969, edited by Batchelor alone after Henderson's death in 1965. Many studies of attempted suicide are mentioned; prominence is given to 'a notable increase in Britain of cases of self-poisoning, particularly with barbiturates and more recently with tranquilizing and other psychotropic drugs... The majority of these acts are impulsive: they are often the response to a quarrel or other frustration of a temperamentally unstable or psychopathic individual.'[184] Batchelor quotes Neil Kessel (who works at the Royal Infirmary of Edinburgh in the early 1960s but overlaps with neither author):

'Kessel (1965) stated that "for four fifths of (these) patients the concept of attempted suicide is wide of the mark... what they were attempting was not suicide." Certainly that there has been an attempt to seek attention and to manipulate the environment is often obvious: but Kessel goes too far in recommending that "we should discard the specious concept of attempted suicide".'[185]

'Attempted suicide' has become a distinctive object within the field of 'suicidal behaviour'; Henderson and Batchelor are never quite convinced that it deserves a *fully* independent existence to the extent of Stengel or Kessel, but certainly acknowledge its 'great importance' post-1945.[186]

The three editions of Mayer-Gross, Slater and Roth's *Clinical Psychiatry* show a similar pattern of emergence. In 1954 the authors note that '[s]*uicide*, or the attempt at it, is often the first alarming symptom of a depressive illness; it is the first and last symptom of many depressive illnesses'. They are clearly aware that there exists a less genuine class of 'attempts', affirming straight afterwards that '[i]n most cases [of depression] these attempts are desperately

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[182] Ibid.
[183] Ibid., pp.73-74.
[184] I.R.C. Batchelor, *Henderson and Gillespie's Textbook of Psychiatry for Students and Practitioners*, 10th ed. (London: O.U.P., 1969), p.72.
[185] Ibid.
[186] Ibid., p.71.

earnest.'[187] A throwaway comment is also made that Freudian psychology is right to emphasise 'the cathartic effect of an attempt at suicide'.[188] The diagnoses most strongly associated with suicide (as a *symptom*) are depression, schizophrenia and psychoses in the aged.[189]

In the second edition (1960) there is a new section devoted to 'Suicide' in the chapter on 'Affective Disorders'. Two separate objects are visible: 'attempted suicide is estimated as occurring with a frequency of four to eight times that of consummated suicidal acts.'[190] Its distinctiveness from 'consummated suicide' is again mapped onto gender: 'almost without exception the rates for men are higher than women while the reverse holds for attempted suicide'.[191] Again, Stengel is mentioned as having 'emphasised the "appeal" character of attempted suicide, the ambiguous or "Janus-faced" attitude directed at once to the reformation of human relationships and towards death. As only a small proportion of attempted suicides completed the act, these individuals could be regarded as distinct from the "successful" suicides.'[192] Once more, the textbook authors are not wholly convinced, arguing that 'although it would be unwise to ignore the appeal element in a suicidal attempt, it would be more dangerous to over-estimate it'.[193]

In the third edition (revised by Slater and Roth after Mayer-Gross' death in 1961), the material from the section on 'Suicide' in the chapter on 'Affective Disorders' is now under its own subheading of 'Attempted Suicide' in a new chapter on 'Social Psychiatry.' Slater and Roth acknowledge '[t]he point made by Stengel and Cook (1958) that these are two separate but overlapping populations is now widely accepted.'[194] They also refer to Kessel's argument that 'attempted suicide is not a diagnosis and not even a description of the behaviour of great numbers of cases coming for treatment under this heading even when the behaviour is clearly a deliberate act of self-injury and not accidental.'[195] They mention three studies of incidence: Kessel's in Edinburgh, Stengel's in Sheffield and Farberow and Schneidman's in Los Angeles.[196]

Thus a clinical object named 'attempted suicide' is rearticulated in two standard psychiatric textbooks after seemingly being brought into focus by Erwin Stengel and associates during the

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[187] W. Mayer-Gross, M. Roth, and E.T.O. Slater, *Clinical Psychiatry*, 1st ed. (London: Cassell & Co, 1954), p.198.
[188] Ibid., p.195.
[189] Ibid., pp.211, 264, 502.
[190] ———, *Clinical Psychiatry*, 2nd ed. (London: Cassell & Co., 1960), p.227.
[191] Ibid. see also E.T.O. Slater and M. Roth, *Clinical Psychiatry*, 3rd ed. (London: Baillière, Tindall & Cassell, 1969), p.793.
[192] Mayer-Gross, Roth, and Slater, *Clinical Psychiatry [2nd Ed.]*, p.229.
[193] Ibid.
[194] Slater and Roth, *Clinical Psychiatry [3rd Ed.]*, p.792.
[195] Ibid.
[196] Ibid.

1950s. Stengel does not *create* this object in any simple way; even without the 'trivial' precipitants in Henderson and Gillespie from 1944, and implied 'non-earnest' or 'cathartic' attempts in Mayer-Gross, Slater and Roth in 1954, it must be emphasised that these ideas do not spring from nothing, yet are also new in quite a precise – clinical-epidemiological – sense. Crucially, it is not until after Stengel, Cook and Kreeger's *Attempted Suicide: Its Social Significance and Effects* (1958) that the textbooks take a coherent position on this phenomenon. This timeframe is supported elsewhere. Psychological clinicians from the 1960s onwards speak of an 'epidemic' of suicidal behaviour that they believe to be novel ('currently fashionable') in important respects,[197] and in modern psychological and sociological literature, the phenomenon of 'attempted suicide' is sometimes seen to 'begin to register' around the 1960s.[198]

In both textbooks this rearticulation of 'attempted suicide' is based upon a shift from 'attempted suicide' as a symptom or outcome of depression, to an object worthy of scrutiny more or less independently of any other psychiatric category. It does not emerge out of 'thin air', but is (re)constituted in a shift from symptom to object. This is an important way in which to conceptualise the 'attempted suicide' object at the centre of this thesis. This shift helps to appreciate the long history of the label 'attempted suicide', and yet deal adequately with its fundamentally contextual and significantly novel nature. It means that various associations can be acknowledged without collapsing everything into a single object, a process which erases the very different practices that produce these different objects, diagnoses and statistics. This new object is first delineated simply by the arrival and survival of certain cases of injury presenting at general hospitals (predominantly after having taken an amount of medication). Through various interviews, investigations, follow-ups and assumptions, a social constellation is actively fabricated around the 'attempt', and meaning projected from the hospital into the social history of the patient.

This thesis charts the 'rise' of a particular set of techniques and institutional practices used to constitute and interpret a particular behaviour pattern between the late 1930s and 1969 in Britain. This does not presume an unproblematic or commonsense existence for this phenomenon, but details the specific conditions in which meaning is produced. It has two principal foci: institutional arrangements that focus consistent psychological scrutiny upon people presenting at general hospitals primarily for 'physical' injuries, and interventions that access and bring to relevance a credible 'social constellation' around the 'attempt'. These are not simply strategies of interpretation or emphasis that enable a pre-existing 'attempted

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[197] E.g. Kessel, "Respectability."

[198] See Aldridge, *Tragedy of Hopelessness*, p.7; Jack, *Women and Attempted Suicide*, p.11.

suicide' to become more visible or coherent. Practical and institutional arrangements and strategies of sense-making *produce* this 'attempted suicide' in a fundamental sense. This study will chart how, when and where 'attempted suicide' emerges and is consolidated into an increasingly common and explicable phenomenon.

The first chapter looks at an object under the name 'attempted suicide' prominent during the early twentieth century (1910s and 1920s), and compares it to one found in the late 1930s, in a mental observation ward attached to a general hospital. This 1937 study marks the emergence of a distinctive 'cry for help' object, acknowledged in the date range for this thesis. The second chapter assesses the significance of the founding of the NHS (1948) for this psychological object, and subjects the work of Ivor Batchelor (1953-56) and Erwin Stengel (1952-58) to close reading, both in terms of their intellectual content and institutional settings. The third chapter takes a close look at the Mental Health Act (1959) and the Suicide Act (1961), to see how various legal changes enable much broader governmental intervention focusing psychiatric attention upon physically injured patients, enabling the object to assume national (even 'epidemic') significance. Chapter four examines a government research unit on psychiatric epidemiology in Edinburgh, and how the profession of psychiatric social work is vital in relating a hospital attendance to a social situation. The fifth chapter shows how despite all the moves towards the integration of psychological and general medicine, a divide endures, but this has the effect of *further entrenching* the transformations from physical injury to psychosocial disturbance. The thesis ends at 1969 with the proposal of the term 'parasuicide' marking the secure establishment of a particular behavioural pattern.

Concluding Thoughts

The history of a particular psychiatric category is important because such categories are constitutive of human possibility. Hacking concludes that through these processes of (self) categorisation 'we are not only what we are[,] but what we might have been, and the possibilities for what we might have been are transformed.'[199] This history of 'attempted suicide' in Britain can show how such coherences can come into use, how possibilities for identity are historically formed.

This contains a vitally important political dimension. As Joan Scott argues, 'by exposing the illusion of the permanence or enduring truth of any particular knowledge… [one] opens the way for change.'[200] The futures from which we are able to choose depend upon what we take to be the meanings of the past, following Paul Connerton: 'we will experience our present

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[199] I. Hacking, *Historical Ontology* (London: Harvard University Press, 2002), p.107.
[200] Scott, *Politics of History*, pp.10-11.

differently in accordance with the different pasts to which we are able to connect the present.'[201] If this position appears paralysing in stressing the multiplicity of the past, then it must also be able to demonstrate, in the words of Nikolas Rose, 'that no single future is written in our present'.[202] In this project, people scrutinised, labelled, interviewed, referred, transferred, arrested, home-visited and otherwise assessed are made into and re-make these categories that render their behaviour somehow intelligible.

Finally, there are significant ethical implications for this kind of history. In contesting the validity of present meanings for describing the past, this thesis makes a point about the possibilities for change. For if present meanings are the only valid ones, and history is merely an exercise in projecting those meanings backwards through time, history comes to *naturalise* the present, and offers nothing in the way of critical engagement. Instead, this thesis argues that the tools through which humans understand themselves and others are contingent, contextual and practical. These labels have *consequences* that cannot be merely shrugged off by citing some eternal, intractable undercurrent, that validates (and is validated by) the imposition of current labels onto the past. We must take responsibility for the labels and descriptions that we use. Collapsing the past into the present is not only bad history, it is totally uncritical, complacent and unethical. This thesis attempts historical *critique*, which

> 'is not a matter of saying that things are not right as they are. It is a matter of pointing out on what kinds of assumptions, what kinds of familiar, unchallenged, unconsidered modes of thought the practices that we accept rest.'[203]

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[201] P. Connerton, *How Societies Remember* (Cambridge: C.U.P., 1989), p.2.

[202] N. Rose, *Politics of Life Itself : Biomedicine, Power and Subjectivity in the Twenty-First Century* (Princeton, N.J. ; Oxford: Princeton University Press, 2007), p.5.

[203] M. Foucault, *Politics, Philosophy, Culture: Interviews and Other Writings, 1977-1984* (London: Routledge, 1988), p.154.

Chapter 1 – 'Attempted suicide' in workhouse infirmaries and observation wards: violence and restraint between therapeutic regimes (c.1900-1943)

At some point before five p.m. on 25th June 1914, in the small coastal town of Lowestoft, Suffolk, fifty-nine year old Louisa Ashby cuts her own throat with a razor, and lies down on her bed. Her eight-year-old granddaughter Dora discovers her covered in blood, and runs back downstairs to inform her mother that 'grandmother had cut her finger'.[1] Ashby is rushed to the nearby Lowestoft and North Suffolk Hospital, where, according to the East Suffolk Police,

> '[t]he [hospital] matron then requested that an officer should stay and take the sole charge and responsibility of the patient. I told her we could not do that, and that two of her sons were present [for this purpose], she said, "They are no good, you brought her here and must take the sole charge of her, or take her away."'[2]

The matron accuses the police of 'not doing your duty… the woman has committed attempted murder [sic], and you should charge her… there is always this bother about cases brought here by the Police, and has been for years' and even threatens to take Ashby and put her outside the hospital gates.[3] Ashby dies two days later.

The dispute reaches the Deputy Chief Constable who is unmoved,[4] quoting East Suffolk Constabulary's General Orders from 1902, to the effect that 'such patients are not in the custody of the police, [thus] he cannot take the responsibility of their safe custody.'[5] The ambiguity around the issue of responsibility is acknowledged in the Home Office's response, but there is one certainty: '[t]he matter is one that can only be arranged by mutual accommodation but it has to be remembered that… the police are responsible for ensuring that… at all events the offence shall not be repeated.'[6]

The Ashby case is just one example of how 'attempted suicide' is constituted differently in different contexts. A Home Office file at the National Archives documents a series of disputes

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[1] Report by P.C. Albert E. Turner dated 29.06.14 [in error], TNA: PRO: HO 45/24439.
[2] Letter from Inspector Fredk. Peck, to Supt. Page, Deputy Chief Constable of East Suffolk dated 17.07.1914, TNA: PRO: HO 45/24439
[3] Ibid. Ashby has committed the common law misdemeanour of 'attempted suicide', not the felony of 'attempted murder'.
[4] '[T]he grievance at the Lowestoft Hospital is the same that has existed for years. The Matron there always insists that the police should take all such persons ['attempted suicides'] into custody'. Copy of Report from Page to Capt. Mayne, Chief Constable, Dated 18.07.1914, TNA: PRO: HO 45/24439
[5] 'East Suffolk Constabulary General Orders' dated 05.03.1902, TNA: PRO: HO 45/24439
[6] Draft Reply to the Chief Constable of East Suffolk dated 05.08.14, TNA: PRO HO45/24439

between hospitals and police forces in England and Wales over patients brought to hospital by police thought to have 'attempted suicide'. On a practical level these records exist due to a debate about the responsibility for the 'would-be' suicide in the absence of a police charge, and whether the cost of watching these patients should be borne by the police.[7]

This financial dispute emphasises characteristics of 'renewal' and 'violence'. Broadly, 'renewal' expresses a concern that the 'attempt' will be *repeated*, usually at the first available opportunity, having *failed* the first time. Thus the 'attempt' is cast as a 'genuine' effort at ending life. Although 'renewal' and 'repetition' are both used interchangeably to describe this concern, 'renewal' is preferred here to emphasise the difference between this object and post-War usage where 'repeated attempted suicide' is a very different object.[8] 'Violence' is largely self-explanatory, but in this context it is not always clear whether it is thought to be predominantly self-directed or towards others, and in the former case is largely indistinguishable from a 'renewal' of the attempt. 'Violence' and 'renewal' emerge because if patients are thought likely to 'renew' their attempt or use 'violence' then the Home Office considers that police are obliged to watch them, or to pay for civilian 'watchers' to ensure that these things do not occur. The obligation is thought to exist even if the person has *not* been charged with the common law misdemeanour of 'attempted suicide' (and therefore not formally in the custody of the police).

The characteristics of 'attempted suicide' are thus bound up with economic concerns. Some police officers see much police time lost on behalf of 'nervous medical superintendents'[9] who push for the watching of most cases; on the other hand hospital staff express resentment at the police bringing in cases that constitute a drain on voluntary hospital funds. In the pre-NHS era, these are charitable funds, either an endowment from a wealthy person, or subscriptions and voluntary contributions from members of the public.[10] Care at voluntary hospitals is considered 'better than the poor law, if one could get it',[11] but this is bound up with being deemed worthy of charitable relief, or having a letter of recommendation from a subscriber or governor.

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[7] It is unclear when the practice of police watching emerges, but it is probable that it comes to renewed prominence in the mid-nineteenth century, when 'attempted suicide' becomes a common law offence, what Anderson calls the 'new offence'. Anderson *Suicide* pp.263-417

[8] See chapter two.

[9] '[F]rom time to time a nervous Medical Superintendent raises the general question.' Minute for File by Norman Kendal (New Scotland Yard), dated 11.07.30, TNA: PRO: HO 45/24439

[10] Gorsky and Mohan define the interwar voluntary hospital as 'a self-governing institution funded principally by philanthropy and contributory schemes rather than by taxation or private payment and in which the consultants and management bodies were mostly honorary and unpaid' M. Gorsky and J. Mohan, "London's Voluntary Hospitals in the Interwar Period: Growth, Transformation, or Crisis?," *Nonprofit and voluntary sector quarterly* 30, no.2 (2001): p.248.

[11] G. Rivett, "The Voluntary Hospitals," in *Development of the London Hospital System 1823-1992.*

Part of this financial dispute mutates into a *therapeutic* dispute (with financial consequences) about 'violence' and 'restraint'. The therapeutic dispute concerns whether the most significant aspect of 'attempted suicide' is the 'somatic' injury, or the presumed 'mental disorder'. Ideas about 'renewal' and 'violence', emphasised in the practical negotiations around police involvement, have another set of resonances with mental disorder through the presumed need for *restraint*. This aspect emerges most clearly at a 1922 inquest into the death of William Bardsley, a clerk from Stockport. Administrators and workers at a voluntary hospital turn Bardsley away, casting these hospitals as unsuitable for 'attempted suicides' because of the potential for violence, which is seen to require the restraining capabilities of mental therapeutics. The 'mental blocks' of workhouse infirmaries (*not* asylums) are considered more appropriate. Bardsley is sent to a workhouse some distance away. The Poor Law Guardians (who admit him) instead emphasise the somatic, surgical needs of his cut throat, claiming that the voluntary hospital is better equipped in that sense. Thus, although 'would-be suicides' appear in the Home Office files due to a financial dispute, their emergence is also related to a negotiation between therapeutic regimes of general and mental medicine. This division is constituted here between voluntary hospitals and workhouse infirmaries, as mental hospitals refuse to take such patients until their physical injuries are stable; they also seem too geographically remote to be realistically considered in an emergency. In 1915 a man is 'not sent to the Asylum before on account of the severity of his injuries… the removal might have been attended with serious results.'[12]

The respective positions of these separate therapeutic approaches shift in 1929-30, as the Local Government Act 1929 abolishes the Poor Law, and the Mental Treatment Act 1930 broadens the scope for uncertified – 'informal' – mental treatment. This brings 'mental' and 'general medical' therapeutics closer together, principally around the old workhouse 'mental blocks' in former Poor Law infirmaries, now called 'mental observation wards' in Local Authority hospitals. The 'secure' function of these wards, as well as the easy availability of 'physical' first aid and psychological assessment, make them particularly suited for the production of an 'attempted suicide' object, through the *transformation* of physical injury into psychological disturbance. Comparison with the Maudsley Hospital demonstrates the continuing association of observation wards with mental illness and the use of restraint, but also as a diagnostic 'clearing station', a place where mental and general medicine interact, forming a distinctive field of visibility.

Finally, the work of Frederick Hopkins at a Liverpool Observation ward can show how these combinations begin to make visible a stable clinical object of 'attempted suicide as cry for

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[12] Letter to Home Secretary from Rev. Canon Gardiner, dated July 1915, TNA: PRO HO 45/24439.

help', through the opportunity for psychiatric scrutiny of patients presenting at hospital due to a 'physical' injury. This object emerges through an uneasy negotiation (and dispute) between the persistently separated approaches of general and mental medicine. General practitioner C.A.H. Watts recalls in 1966 that '[f]ew of us who qualified in the middle [nineteen-] thirties found ourselves equipped with any knowledge of psychiatry… Medicine in those hospital days was almost completely an affair of organic diseases, and any psychiatric casualty was viewed as the *usurper of a useful hospital bed* – something to be removed with almost unseemly haste.'[13] The practice of mental and general medicine changes, as do the differences and negotiations between them. However, because 'attempted suicide' is consistently seen as involving a physical element (the 'self-inflicted injury') and a mental element (anyone wanting to injure themselves must be mentally disordered in some way), it emerges reliably, though in a variety of ways, between these two regimes.

'Renewal', responsibility and economics

In the case of Louisa Ashby, the Home Office decides that it is the police's responsibility to ensure that 'at all events the offence shall not be repeated'. This concern with repetition or renewal in debates about responsibility also surfaces in a dispute over one Frederick Newman in Wiltshire in 1915. In this case the Home Office decides that 'it would appear that though no charge of attempting suicide was made against him there was some risk of his repeating the attempt.'[14] The police are reluctant to charge a person with the offence of attempting suicide, because this involves taking responsibility for them and yet hospitals consider them as patients that need to be watched. The legal ambiguity leads to the articulation of 'would-be suicides' according to the quality of 'repetition' or 'renewal'.

However, as shown by the Ashby case, legal 'responsibility' is bound up with economic concerns. The Clerk of Lowestoft Hospital's Management Committee initiates the exchange with the Home Office in 1914, emphasising 'the heavy expense which the Institution has to bear in the care of these Patients'.[15] The Home Office is clear on this point, advising the police that 'if as appears to be the case the Lowestoft Hospital is under private management and is supported entirely by voluntary contributions, the police have no very clear claim on the services of the staff in respect of cases brought there by them.' In addition, 'Mr. McKenna

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[13] C.A.H. Watts, *Depressive Disorders in the Community* (Bristol: John Wright & Sons, 1966), p.1. Emphasis added.

[14] Letter from Home Office to Deputy Chief Constable of Wiltshire dated 16.08.1915, TNA:PRO: HO 45/24439.

[15] Letter from W. Bryan Forward (Lowestoft & North Suffolk Hospital) to Home Office, dated 06.06.1914, TNA: PRO: HO45/24439.

[Home Secretary] would be glad to know whether the question of making some contribution to the Hospital from Police funds has been considered.'[16]

Economics are also a concern for the police. In a 1923 letter from the Metropolitan Police to the British Hospitals Association, it is argued that 'in the urgent interests of economy it has been deemed necessary to… curtail the services of the Police in those directions in which the duties are of such a nature as cannot strictly be held to devolve upon them'. Thus they are 'unable to sanction the employment in all cases of Police Officers to watch would-be suicides, but he will be prepared to do so in the comparatively few instances where the patient exhibits a desire to repeat the attempt, or is really violently disposed.'[17] Here again, 'would-be suicides' emerge according to the terms of a specific debate around economics, to do with 'repetition' and 'violence'.[18] In Liverpool in 1920, '[i]t is not suggested that the Police should supply watchers for all persons whom they may take to a hospital or infirmary after attempted suicide, but only that they should do so when there is reasonable ground for fearing that the attempt at suicide will be renewed or that other violence may be used.'[19] This economic concern brings out 'renewal' and 'violence' together.

The absence of a police charge creates an ambiguous situation as to who is responsible for the 'would-be suicide', a question with unmistakable economic overtones. This ambiguity is negotiated with an assessment of potential 'renewal' or 'violence'. Thus a key quality of this object of concern (its potential to be repeated) emerges directly as a function of the specific contextual argument.

'Violence' and separated therapeutics

However, 'violence' has a different salience in debates over whether 'would-be suicides' should be treated in workhouse infirmaries or voluntary hospitals. Workhouse infirmaries are places where mental and general medical therapeutics co-exist to a greater extent than in many other institutions. This boundary between therapeutic regimes in the articulation of 'attempted suicide' persists throughout this thesis. However, it is constituted and negotiated in different ways in different contexts. In this particular discussion, the issue of appropriate

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[16] Letter from the Home Office to Chief Constable of East Suffolk dated 05.08.14, TNA: PRO: HO 45/24439,

[17] Letter from Commissioner of Police for the Metropolis to the Secretary of the British Hospitals Association dated 26.01.1923, TNA: PRO: HO 45/24439.

[18] The idea of a charge for cases where repetition is anticipated is seen as largely common sense in a Metropolitan Police statistics file, mentioning 'cases in which proceedings are taken by the Police, i.e. where it is likely that further attempts will be made or where there is nobody to take charge of or be responsible for the offender.' minute for file dated 09.11.1933 in 'Suicide & Attempted Suicide: analysis of methods employed and motives recorded', TNA: PRO: MEPO 2/6955.

[19] Minute on file by H.B. Simpson (draft letter to F. Caldwell) dated 26.10.20, TNA: PRO: HO 45/24439.

care is brought to light in ways that still feed off the 'violence' and 'economic' concerns outlined above.

In 1907, a Home Office ruling on the correct place for 'attempted suicides' to be taken does not mention the facilities for treatment, but a more diffuse sense of the 'character' of certain cases. There is a legal obligation to admit emergencies to both workhouses and voluntary hospitals, but 'police should use discretion' when asking to admit cases to voluntary hospitals 'different in character from those which are ordinarily received there.'[20] This concern about the 'character' of the cases is predominantly a concern with the *type* of case, rather than the *character of the patient*. It is possibly a continuance of what Geoffrey Rivett notes of early nineteenth-century voluntary hospital emergencies: '[m]edical staff made a rapid assessment of the clinical priority of those attending, who were well aware that a judgment was also being made on whether they were fit objects of charitable relief.'[21] Moral judgements bound up with charity could well continue to militate against admitting 'attempted suicide' cases to voluntary hospitals in the early twentieth century. Whilst the Home Office clearly implies that 'attempted suicides' are 'different in character' from other voluntary hospital cases, both places are considered – from a legal standpoint in any case – equally valid.

In 1920 it emerges that the Liverpool Police judge the workhouse infirmary *especially suited* for 'attempted suicides' as '[i]t is not the practice… to take attempted suicide cases to voluntary hospitals', and therefore 'the cost of hiring further attendants [police watchers] to go to workhouse infirmaries where *already there are qualified persons*, hardly seems justified.'[22] This has turned from a diffuse and ambiguous concern about the type of cases admitted (with possible moral overtones) to a debate about *therapeutic facilities* – but still interwoven in a different way with economic questions. This feeds into an explicit statement about the potential 'violence' of such cases: '[t]he official nurses [at workhouses] are expected to supervise mental patients, dangerous at times, when the risk of attack or injury to their attendants is much greater than that incurred through the care of suicidal persons whose violence would be probably only an attempt at further self-destruction.'[23] Thus facilities at the workhouse infirmary are implied to be appropriate for dealing with both the somatic consequences and the potentially dangerous 'mental' aspect of these cases. The Home Office response does not attempt to alter the terms of the debate. Whilst reiterating the position that 'violence' is key in cases of 'attempted suicide', the argument also takes in the capabilities

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[20] Draft Letter from Home Office to Huntingdon Constabulary dated 11.07.07, TNA: PRO: HO 45/24439.
[21] Rivett, "The Voluntary Hospitals."
[22] Letter from Chief Constable of Liverpool (Caldwell) to Home Office dated 21.10.1920, TNA: PRO: HO 45/24439. Emphasis added.
[23] Ibid.

of 'ordinary' (i.e. not trained to deal with mental illness) hospital staff. The position is that '[t]he police should pay for watching of patients 'when there is reasonable ground for fearing that the attempt at suicide will be renewed or that other violence may be used and the ordinary hospital staff is insufficient to prevent it.'[24] The idea of a potentially 'violent' 'would-be suicide' is in a central position in an economic battle that is also fought on the terrain of 'appropriate facilities'.

It is unsurprising that 'attempted suicide' is constituted on a specific continuum of 'violence' when the whole administrative machinery by which such cases are looked after – and their care paid for – hinges upon assessments of potential 'violence'. But the debate about potential violence is also inextricably bound up with the question of how far an 'attempted suicide' indicates mental illness.

A 'joy ride' between separated therapeutic regimes

The intimate relationship between assessments of violence and the suitability of general or mental therapeutics (and how this also links in with economic concerns) is clearly illustrated by a 1922 dispute at Ashton-under-Lyne, a small town between Manchester, Oldham and Stockport in the North-West of England. The inquest following a man's death causes enough of a stir to be covered by the London *Evening Standard* and the *Manchester Guardian*. On 27th January William Bardsley, a clerk from Stockport, arrives at the District Infirmary, Ashton with a cut throat. He is refused admission and taken to the Lake (Workhouse) Hospital, where he is admitted as an emergency, even though he is not from an area covered by that Poor Law Union. At the inquest into his death it is observed that one result of the dispute (between mental and somatic therapeutics) is that the patient is ferried between institutions: '[i]t is very hard to give a dying man a "joy ride" between hospital and hospital'.[25] This is a clear indication of the *separation* of one type of scrutiny from another, which is particularly problematic in emergency cases. The dispute over the appropriate care of 'attempted suicides' is articulated in terms of 'attempted suicide as physical injury' (appropriate for voluntary hospitals) against 'attempted suicide as mental disorder' (appropriate for the mental block of Poor Law infirmaries).

The roots (and often the buildings themselves) of what become observation wards lie in the 'mental blocks' of Poor Law infirmaries like the Lake Hospital. Hugh Freeman notes that Poor Law Union infirmaries are built during the 1860s to care for the increasing number of

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[24] Letter from Home Office to Chief/Head Constable of Liverpool dated 01.11.20, TNA: PRO: HO 45/24439.

[25] Attributed to Rev. Canon O'Grady in 'Man with cut throat' *The Reporter* 04.02.1922, TNA: PRO: HO 45/24439.

workhouse occupants who are 'ill or decrepit', and further, that 'most infirmaries had an observation unit or "mental block"', where cases are admitted and then either transferred to a mental hospital or discharged.[26] After the Lunacy Act of 1890, which 'consolidated previous legislation on emergency admission', observation wards are set up and 'mainly sited in Poor Law hospitals, and aimed to provide initial assessment of mental illness as a preliminary to admission to a mental hospital.'[27] St. Francis' observation ward in South London, the clinical anchor for Stengel's *Attempted Suicide* (1958) is part of the Constance Road Workhouse from 1895 until 1930, when the institution is renamed St. Francis' Hospital.[28] During the workhouse period, patients are admitted under the emergency sections (20, 21 and 24) of the Lunacy Act 1890 and there is 'little distinction between social care for the poor and medical services for the "pauper lunatic"'.[29]

At the start of the Ashton controversy, a letter is sent to the Guardians of the Lake Hospital, explaining the (voluntary) District Infirmary's position. Some time before the incident occurs, a pre-emptive letter is sent by the Infirmary to the local police asking them 'not to send to the District Infirmary cases which they might have cause to consider were cases of attempted suicide.'[30] The extent to which this relies upon the 'attempted suicide' being cast as a mentally ill rather than physically injured case is clear:

> '1. That it is a rule of the District Infirmary that persons of unsound mind should not be admitted as patients. 2. That most juries find that a person who commits suicide does so while temporarily insane. 3. That under a Home Office Regulation the Police are not now called upon to provide an Officer to watch over such cases where the patient is not under arrest. 4. To send such a person to an Infirmary like the District Infirmary, Ashton-under-Lyne, is liable to cause distress to other patients, and considerable dislocation and possible addition to the staff.'[31]

It is not particularly original to project mental illness backwards into the past history of a patient from the point of an 'attempted suicide', but it is not *inevitable* that this should

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[26] H.L. Freeman, "Psychiatry in the National Health Service 1948-1998," *British Journal of Psychiatry* 175(1999): p.3.

[27] R. Mayou, "The History of General Hospital Psychiatry," *The British Journal of Psychiatry* 155, no.6 (1989): p.768.

[28] King's College London Archives and Corporate Records Services 'Administrative History' [http://www.kcl.ac.uk/depsta/iss/archives/collect/1sa40-0.html#BIO] accessed 28.08.11.

[29] M.D. Eilenberg, M.J. Pritchard, and P.B. Whatmore, "A 12-Month Survey of Observation Ward Practice," *British Journal of Preventive and Social Medicine* 16(1962): p.22.

[30] Letter from F. Oliver (District Infirmary) to H. H. Daley (Lake Hospital) dated 01.02.1922, TNA: PRO: HO 45/24439. See also Staffordshire Constabulary Memo, dated 30.12.1910, TNA: PRO: HO 45/24439.

[31] Letter from Oliver to Daley, 01.02.1922.

happen.[32] In the four above points, mental state, police practice and financial cost ('addition to the staff') are woven together to cast 'would-be suicides' as 'mental patients' more suitable for the workhouse mental ward attendants.

The importance of appropriate staff/facilities is demonstrated by the coroner at the inquest,[33] who invokes the concerns about 'violence', stating that 'he understood the Infirmary authorities could not take cases of suicide [sic] because they had not the necessary staff to deal with patients who might become violent.'[34] The very fact of a cut throat is seen to evince a suicide attempt which, in turn implies violence. This chain of associations is constructed through the argument that the facilities at the District Infirmary are unsuitable, thus they should not provide (or pay for) treatment.

The following exchange in a coroner's court shows how seemingly exclusive mental and physical therapeutics become absolutely vital to the resolution of this case. Dr O'Connor, Assistant Medical Superintendent at the Lake (Workhouse) Hospital argues that 'the patient should have been detained at the Infirmary where the staff had more experience of surgical cases, and was more accustomed to dealing with them'.[35] He explicitly casts the case as one of somatic injury – a surgical question. The coroner responds that 'there were no male nurses at the Infirmary', which is utterly incomprehensible – given the irrelevance of nurses of any gender to the propriety of surgical procedures – unless it is seen as bringing the argument back to a debate about *restraint*. H. Hall Daley (Clerk to the Guardians at the Lake Hospital) clearly understands this as he replies that they do not have any male nurses either, '[w]e only have the mental ward attendants.'[36] The Coroner's reply explicitly casts 'attempted suicide' as more appropriately ministered to by 'mental' over 'general medical' therapeutics, and from there, elides straight into a supposition of potential violence through the method of injury: '[w]ell, a case like this is treated *more as a mental case*. At the Infirmary I am told they don't receive cases where violence has been used.'[37] Violence again emerges here explicitly as a function of a debate about appropriate hospital provision, across a psyche/soma split. However, O'Connor is not done, and attempts to drag the case back onto somatic terrain, where the 'attempted suicide' would be more suitable for the Infirmary: 'in cases of haemorrhage it was essential that a person should be attended to as speedily as possible, and the Infirmary was equipped

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[32] Such blanket attributions are explicitly contested by the psychiatrists concerned with the post-1945 'attempted suicide' such as Neil Kessel or Erwin Stengel. See N. Kessel, "Self-Poisoning (1)," *British Medical Journal* 2, no.5473 (1965): p.1269; E. Stengel, "The Risk of Suicide in States of Depression," *Medical Press* 234(1955): p.184; chapters two and four.
[33] No representatives from the Police or District Infirmary attend; the coroner states the opposing case.
[34] 'Man with cut throat' *The Reporter* 04.02.1922.
[35] Ibid.
[36] Ibid. Emphasis added.
[37] Ibid. Emphasis added.

for that class of work.' Daley adds that 'the Infirmary, which largely existed for surgical cases, was better equipped to deal with that class of patient.'[38]

The negotiation and rearticulation of psyche and soma is achieved across a divide between workhouses and general hospitals. These positions are *not disputed*, and Daley openly acknowledges the presence of mental nurses. The debate is pursued through a contest over whether the essence of a case of 'attempted suicide' is 'mental' or 'physical'. The contested essence in this particular context enables 'violence' to be consistently invoked. Thus the potential 'violence' that emerges in this 'facilities debate' is structured around a division between therapeutic technologies.

The *Manchester Guardian*'s report emphasises the financial aspect over the therapeutic dispute.[39] However, rather than reduce the significance of the case to any one 'primary cause', it is useful to sketch out the arguments pursued in a number of different registers. The arguments that reach the Home Office are more likely to involve the spending of public money and the police, whereas those issues recede in a coroner's court where it is a question of establishing fault or not in a particular death. This becomes transposed onto the technical question of facilities (which is accepted by both parties), and the question of facilities best equipped to deal with violence. The point here is to lay out a field of argument that is structured by a specific mental/physical divide, and to see how 'attempted suicide' emerges in this field – characterised by potential 'renewal' and 'violence'.

Differences and similarities – rupture and continuity?

The characteristic of 'violence' is almost totally absent from the post-1945 epidemic of 'attempted suicide'. It might be argued that this is because 'self-poisoning' – the predominant method between 1948 and 1969 – is a 'passive' method and that 'cut throats' – the method for the overwhelming majority of cases that emerge in tandem in 'police watching' and 'facilities' disputes – is an active and violent method. However, this thesis seeks to understand why certain methods emerge in certain contexts, in the course of specific debates.[40] In a dispute involving police presence and the division between mental and general medicine, it is no wonder that violence and repetition come to the fore. Dealing with violence through restraint is seen as a key part of the job for mental ward attendants and the police (in their different ways), so the cases involving arguments for or against the presence of these professionals are likely to be described in those terms.

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[38] Ibid.
[39] 'Hospitals and the Home Office' *Manchester Guardian* 29.04.1922.
[40] See chapter four for the wider resonance of drugs concerns post-1948.

This thesis also seeks to account for how certain actions come to be seen as 'violent' or 'passive'. If it is accepted that there is no single essence or essential quality to *any* action independent of context, we can investigate how certain actions come to be classified as violent or passive or (self-) destructive. Perhaps because a cut throat usually involves a bladed object (considered in this context as more generally and immediately dangerous than a bottle of pills, for example), and perhaps because its repair seems to require the distinctly somatic specialism of surgery, this method seems most obviously to call for police involvement and also to straddle this somatic/psychiatric divide.

As for 'repetition' or 'renewal', the second key quality to emerge from the disputes negotiating the divide, it might be argued that this has nothing to do with the 'terms of the debate' and that it is merely logical that a person who attempts to commit suicide and 'fails' would be likely to try and renew the attempt, to 'succeed' or 'complete' the suicide. However, it is precisely a *disruption* of this 'logic' that undergirds the post-war epidemic, which is positioned *against* the equation of 'attempted' with 'bungled suicide'. The idea of 'repeated' suicidal attempts certainly emerges in the post-1945 discussions, but this 'repetition' is cast as a repeated response to social situations, an habitual coping mechanism, rather than an immediate attempt to rectify the 'failure' of the first attempt.[41] This reading is guaranteed by notions of 'social stress' broached in the introduction. It also shows how wide-reaching changes follow when instances of 'self-inflicted injury' become articulated in a specific psychiatric idiom.

However, if the 'violence' largely disappears and the 'repetition' is reconstituted into something different, one aspect of the 'police watching' debate flags up a subtle link between the 'attempted suicide' articulated in the 1920s and the one in the late 1950s and 1960s, in addition to the idea that in both cases 'attempted suicide' emerges between separate therapeutic regimes. This is the issue of 'friends and relatives'. Throughout the debate, the Police consistently state that they are to employ 'watchers' only until friends or relatives can be found to 'take charge of the case'. An order for East Suffolk Police from 1902 states that they will only pay for watchers 'where the person has no friends or relatives able to take care of him, or when such friends or relatives are unwilling to perform or pay for such a service.'[42] A Staffordshire Police Order from 1904 states that '[i]t is always open, to friends or relations… to make such provision as they think fit for the care and medical treatment of these persons'.[43] Initiating a Metropolitan Police Order in 1916, the Commissioner states that the 'discretion' on the issue of charging a person or not 'has been based partly on the question whether the

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[41] See chapter two.
[42] East Suffolk Constabulary General Orders, 05.03.1902.
[43] Standing Order no.7 from Staffordshire Constabulary 'Cases of Persons who have attempted to Commit Suicide' dated November 1904 , TNA: PRO: HO 45/24439.

offender had any friends or relations willing to take charge of him.'[44] The consistent use of family and friends – and indeed the idea of 'watchers' being a substitute for them – is a convenient *administrative response* to deal with legal ambiguity and 'nervous medical superintendents' which stems from the reluctance of voluntary hospitals to be associated with potentially 'mental patients'. Such patients are considered unsuitable for general hospital admission, necessitating special arrangements.

So whilst the notion of 'attempted suicide as cry for help' has broad ancestry, it is possible that the understanding of 'attempted suicide' as *primarily* a communication with a social circle can become more 'self-evident' if the first response of the police is to contact members of that social circle to come and watch over the attempter (a practice that does not totally disappear until 1961). This is *not* a case of one state of affairs 'anticipating' another, or being a 'prototype' of a later articulation of 'attempted suicide'. In this period, ideas about the *causes* of psychological illness move away from concerns about heredity, the nervous system, or brain lesions, and begin to focus more upon social relationships, emotional attachments and adequate adjustment (in infancy and adulthood), all things that place other people in a vitally important position for a person's mental health.[45] Thus, what begins as an *administrative* response to a suspected 'attempted suicide' can obtain new *intellectual* resonance and salience. A practice rooted in the fear of 'renewal' in general hospitals, in a legally ambiguous situation, might also provide a basis (and an audience) for a 'cry for help'.

'Police watching' constitutes 'attempted suicide' as the site at which confusion is most keenly felt over the roles of the legal and medical professions in ministering to certain kinds of injuries (principally a cut throat) that require hospital treatment. Legal ambiguity, financial pressures (on both hospitals and police) and the separation of psychiatric and general medicine create a field of visibility for 'attempted suicide' that emphasises 'renewal' and 'violence' as the two key characteristics. There is no sense of a 'cry for help' in the Home Office and Metropolitan Police files; instead there is a danger of repetition and a threat of violence (which does not differentiate consistently between a renewed 'attempt' and violence towards others). Indeed, the fear of renewed attempt – which is the basis for employing a watcher – seems to at least imply some sort of earnest desire to kill oneself. The police contest that a watcher is always necessary, but there is no sense of a 'communicative demonstration'. However, the consistent invocation of 'relatives or friends' (the first port of call to watch the people recovering from an

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[44] Letter from Sir Edward R. Henry (Metropolitan Police Commissioner) to Home Office dated 27.07.1916 in 'Police Supervision of AS in Hospitals', TNA: PRO: MEPO 3/2436.
[45] See introduction.

'attempt') might buttress – in the context of a separate debate – the apparent self-evidence of an 'attempt at suicide' performed as a communication to a social circle.

The debates recounted here form a curious counterpoint to Stengel's lament in the late 1950s about the lack of 'machinery' for the registration of 'attempted suicide'. In the 1920s, 'would-be suicides' emerge precisely *because* there is no single administrative, legal or medical body to take responsibility for those judged to have 'attempted suicide'. A more systematic process of recording emerges when the therapeutic regimes are not seen as a 'joy ride' away from each other. This begins to happen in the 1920s and 1930s, as the workhouse infirmaries are consolidated into local authority hospitals, and come to contain the potential for both mental and general medical scrutiny, a reconstitution of an enduring therapeutic separation.

From Workhouse Infirmary to Mental Observation Ward (1929-1930)

The disputes in the 1910s and 1920s bring 'would-be suicide' or 'attempted suicide' to light through a process of negotiation between the distinct therapeutic regimes of the voluntary hospital, and the mental block of the workhouse or Poor Law infirmary. However, these blocks and observation wards come to form much more of a liminal space between therapeutic regimes than suggested by the polemic pursued in the Ashton inquest, an institutional space that becomes more prominent during the 1930s as a mental observation ward. The rise of this institution is implicated in the broader story of mental-general medical integration that reaches its legislative zenith in the Mental Health Act 1959, but has a more obscure early twentieth-century history. Again, to discuss the attempted integration of two broad therapeutic regimes ('general medical' and 'psychiatric') is not to imply that the regimes are monolithic or undifferentiated within themselves; the differences between them are also produced, maintained and negotiated within specific historical contexts – the differences may be self-evident *within these contexts*, but are historically established, not universally true.

To sum up mental observation wards in early-to-mid-twentieth century Britain is no simple task. Richard Mayou, founder and first chairman of the Section for Liaison Psychiatry at the Royal College of Psychiatrists, laments that '[l]ittle is known of how they operated.'[46] They vary widely in their functions and available resources, according to place and over time. This unevenness of available expertise and facilities renders any sense of a 'typical' observation ward particularly illusory. These disclaimers notwithstanding, an inter-war observation ward might cautiously be characterized as having two main functions: first, as a place for the initial assessment of psychological disorder with regard to mental hospital admission; second, for the

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[46] Mayou, "General Hospital Psychiatry," p.768.

temporary care of cases deemed acute, disruptive or difficult – often with the implication that mental abnormality is behind such behaviour.

In 1940, Ian Skottowe[47] describes one class of observation unit as 'the modern development of the old workhouse observation wards of a generation ago',[48] and the workhouse heritage of the mental observation ward is widely acknowledged in the literature produced in the early 1960s around district general hospital psychiatric units.[49] Donal Early notes in 1962 that his Bristol observation ward has roots in 'Public Assistance'. He recalls that prior to the inauguration of the NHS in 1948, 'cases (other than those under the Lunacy Act [1890]) were admitted to the Public Assistance Institution [workhouse], as it then was, via these [observation] wards.'[50] A year later D.R. Benady (a Senior House Officer), and John Denham, Consultant Psychiatrist[51] working at St Clement's Hospital in London note that 'the observation wards [are] situated mainly in the poorer municipal hospitals or [former] Poor Law institutions of the great cities' of Britain.[52] In Pickstone's 1992 case study of general hospital psychiatry in Manchester, he mentions that 'the ex-workhouse mental blocks... afforded the opportunity for an alternative mode of development' for psychiatric practice not centred on the county asylums.[53]

The wards are transformed around 1929-30. First 'the Local Government Act [1929] placed the old Poor Law Hospitals under local authority control'.[54] An unpublished 1938 report on observation wards (again, in London) comments that the 'chief feature of the [1929] reorganisation of the observation wards in the Metropolitan area has been the concentration of these wards in six General Hospitals'.[55] In 1940 it is deemed desirable that these wards

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[47] A gifted administrator and clinician, influenced by D.K. Henderson and remembered as sceptical of 'psychiatric over-encroachment into the field of behaviour and personality disorders'. S.J.G.S., "James Stuart Ian Skottowe," *The Psychiatrist* 8, no.7 (1984): p.143.

[48] I. Skottowe, "Discussion: Observation Units," *Proceedings of the Royal Society of Medicine* 33(1940): p.732.

[49] See chapter five.

[50] D.F. Early, "The Changing Use of the Observation Ward," *Public Health* 76, no.5 (1962): p.261. Erwin Stengel works in Bristol in the early 1940s, producing E. Stengel, "On the Aetiology of the Fugue States," *The British Journal of Psychiatry* 87, no.369 (1941).

[51] A man who '[l]ong before the terms "community care" and "crisis intervention" became commonplace, it was frequently his practice to visit patients at home as a means of preventing their admission to hospital by dealing with their problems in the settings in which they lived.' S.I.C., "John Denham," *Psychiatric Bulletin* 9(1986): p.127.

[52] D.R. Benady and J. Denham, "Development of an Early Treatment Unit from an Observation Ward," *British Medical Journal* 2, no.5372 (1963): p.1569.

[53] J. Pickstone, "Psychiatry in District General Hospitals," *Medical Innovations in Historical Perspective* (1992): p.198.

[54] Armstrong, *Political Anatomy*, p.73.

[55] Lewis and Calder 'General Report on Observation Wards' p.1. See also Mayou's slightly different assessment, Mayou, "General Hospital Psychiatry," p.768.

should be 'part of, or closely attached to, a general hospital'.[56] In 1962 it is noted that '[t]he Local Government Act, 1929, empowered the London County Council to appropriate to their health service any workhouses used for hospital purposes'. In addition to the 1929 Act, 'Section 19 of the Mental Treatment Act, 1930, allowed the use of these institutions for the detention of mental patients.'[57] Thus the wards are further entrenched into both general medical *and* mental therapeutics. Not only are the wards brought closer to general hospitals, they are assigned a role (initial assessment) under the Mental Treatment Act of 1930 on a national scale. They are central to integration.

The 1930 Mental Treatment Act (or the Royal Commission on Lunacy and Mental Disorder (Macmillan Commission) (1924-26) that precedes it) is often used as the starting point for twentieth century historical narratives of the integration of general and mental medicine in Britain. Walter Symington Maclay joins the Board of Control at the end of the Second World War and is its Senior Medical Commissioner when it is dissolved by the 1959 Mental Health Act.[58] He continues at the Ministry of Health for a short time as a Principal Medical Officer before his death in 1964. It is remarked after his death that of those who 'have tried to bring psychiatry into the stream of the rest of medicine there are few, if any, with a more honoured name'.[59] When in 1963 he lays out three key twentieth-century events for psychiatry, he begins with '1930, when the Mental Treatment Act for the first time allowed voluntary admissions to mental hospitals and development of outpatient departments on a national scale'.[60] For Maclay, this is a key date for 'English psychiatry', showing how this particular process of integration is seen to represent progress *in general*.[61] For him, the story of twentieth-century psychiatric progress seems identical with the processes of integration between general and psychiatric medicine.

The Act's integrative impact is widely recognised. In *Social Science and Social Pathology* (1959), Barbara Wootton quotes the Macmillan Commission's recommendation that the law should be changed so that 'the treatment of mental disorder should approximate as nearly [as possible] to the treatment of physical ailments'.[62] Maclay argues that whilst the Lunacy Act (1890) and Mental Deficiency Act (1913) are important, it was 'the 1930 Mental Treatment Act which

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[56] E.N. Butler, "Observation Units," *Proceedings of the Royal Society of Medicine* 33(1940): p.731.

[57] Eilenberg, Pritchard, and Whatmore, "Observation Ward Practice," p.22.

[58] A.D., "Obituary Notices: Hon. W.S. Maclay," *British Medical Journal* 1, no.5392 (1964): p.1258.The Board of Control is responsible for the administration of mental health services, and is included in the NHS, until dissolved by the 1959 Mental Health Act.

[59] Ibid.

[60] Maclay, "Appraisal of English Psychiatry," p.100.

[61] 'For English psychiatry, there have been three important dates in this century' Ibid.

[62] Whilst also preserving safeguards against the unjust infringement of liberty. B. Wootton, *Social Science and Social Pathology* (London: George Allen & Unwin, 1959), p.208.

ushered in the era of mental disorder as an integral part of medicine'.[63] It allowed local authorities to establish psychiatric outpatient clinics, and treat patients without formal 'certification',[64] integration that was also helped by the appropriation of observation wards by local health authorities. 'Voluntary boarder' status under the 1890 Act and 'voluntary treatment' under the 1930 Act require written consent but Mayou is right to argue that the 'Mental Treatment Act 1930 encouraged a greater role for the general hospitals and made voluntary treatment of major [mental] illness possible'.[65] It is not often made clear enough that observation wards constitute a key intersection between *general hospitals* and mental medicine.

This has specific relevance here due to the casual but enduring association between observation wards and an object labelled 'attempted suicide'. In 1937, the *Journal of Mental Science* publishes an article by E.U.H. Pentreath and Eric Cunningham Dax describing their work on St. Francis' ward.[66] Pentreath is a rather obscure figure who has already moved to the Derby County Mental Hospital at Mickleover (later Pastures Hospital) at the time of publication; not much else is recorded about him. Dax is remembered as an enthusiast for somatic therapies, including ECT, insulin coma and leucotomy whilst in Britain, and as a 'larger-than-life persona' after emigrating to Australia to become head of Victoria's Mental Hygiene Authority (1952-1968).[67] Two therapies described as his 'pet projects' for patients under his care, leucotomy and art therapy, give a flavour of his eclecticism.[68]

'Attempted suicide' appears in Pentreath and Dax's study as a distinct object: they mention '33 cases of attempted or threatened suicide' admitted under section 20 of the Lunacy Act[69] and '12 suicidal attempts' admitted by police officers.[70] No further comment is given; the 'attempted suicides' are not seen as a *special* target for investigation, but they are a separate entity. In the abovementioned unpublished report, carried out in the six London County Council (LCC) observation wards for the Maudsley Hospital by Aubrey Lewis and Flora Calder in

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[63] W.S. Maclay, "Trends in the British Mental Health Service," in *Trends in the Mental Health Services: A Symposium of Original and Reprinted Papers*, ed. H.L. Freeman and W.A.J. Farndale (Oxford: Pergamon Press, 1963), p.4.

[64] The 1890 and 1930 acts are connected: '[t]he 1930 Act, in accord with the Macmillan recommendations, extended the voluntary boarder system of the 1890 Act.' A. Rogers and D. Pilgrim, *Mental Health Policy in Britain*, 2nd ed. (London: Macmillan, 2001), p.55.

[65] Mayou, "General Hospital Psychiatry," p.767 (which refers to C. Unsworth, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987)).

[66] E.U.H. Pentreath and E.C. Dax, "Mental Observation Wards: A Discussion of Their Work and Its Objects," *The British Journal of Psychiatry* 83, no.345 (1937).

[67] A. Westmore, "Eric Cunningham Dax (1908-2008); a Tribute," *Health and History* 10, no.1 (2008): p.167.

[68] Ibid.: p.169.

[69] Pentreath and Dax, "Observation Wards," p.351.

[70] Ibid.: p.352.

1938, patients 'with suicidal tendencies' are counted among the groups 'peculiar to observation wards.'[71] Similarly, Frederick Hopkins of Smithdown Road Hospital, Liverpool in 1943 claims that there are 'three fairly common reasons for admission for observation… attempted suicide, epilepsy, and G.P.I. [General Paralysis of the Insane].'[72]

Observation wards and the Maudsley Hospital

The position of observation wards, the debates about their function, and the specific practices carried within them after 1930 is significantly clarified by a comparison with the Maudsley Hospital. It can be seen from these connected histories (with special focus on the respective admissions policies and legal obligations) how different diagnoses emerge in different contexts. Lewis and Calder imply that observation wards and the Maudsley are concerned with broadly the same field, noting that '[t]he observation ward system is not the only provision made by the London County Council for dealing with mental patients at the earlier stages of their illness', meaning the Maudsley. This is 'supplemented on a large scale by services established at the Medical Schools and other important voluntary bodies.'[73] However they also note that 'the observation wards are somewhat isolated from the whole system of the mental health services.'[74] Through the following comparison, the changing role of observation wards in diagnostics, restraint and treatment can be more clearly seen, their position between psychic and somatic therapeutics more precisely demarcated, and their enduring association with 'attempted suicide' interrogated more fully. The contrast can show why 'attempted suicide' – an increasingly influential object of *psychiatric* epidemiology throughout the 1960s – might *first* crystallize more often in the rather neglected observation ward, rather than the prestigious and world-leading Maudsley Hospital.[75] This comparison focuses specifically upon notions of security and restraint as key in associations between institutions and 'attempted suicide'.

The Maudsley Hospital opens in January 1923 aiming for 'effective treatment for neuroses, mild forms of psychosis and dependency disorders.'[76] It is 'the first British mental hospital to

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[71] A. Lewis and F.H.M. Calder 'A General Report on the Observation Wards Administered by the London County Council' (1938) p.10 , TNA: PRO: MH 95/32.

[72] F. Hopkins, "Admissions to Mental Observation Wards During War," *British Medical Journal* 1, no.4289 (1943): p.358. See Hopkins, "Attempted Suicide," p.71, and below.

[73] Lewis and Calder 'General Report' p.2.

[74] Ibid.: p.21.

[75] The focuses on the six principal London observation wards: Fulham, St. Pancras, St. Clements (Bow Road), St. Alfeges (Greenwich), St. Francis (Dulwich) and St. John's (Battersea). It should be noted that Lewis and Calder argue that observation ward practice in London should not be presumed relevant for all England and Wales. Ibid.: p.2.

[76] E. Jones, S. Rahman, and R. Woolven, "The Maudsley Hospital: Design and Strategic Direction, 1923–1939," *Medical History* 51, no.3 (2007): pp.357, 363.

accept voluntary patients.'[77] The voluntary status of its patients is significant, for under the terms of the 1890 Lunacy Act 'no local authority could pay for the treatment of mental illness unless the patient had been certified. Hence the statute imposed strict limits on the type of disorder that could be treated in an asylum'[78] funded by local authorities. This constraint is removed by the Mental Treatment Act 1930, but prior to that, the Maudsley is 'granted administrative freedoms denied to most UK institutions'.[79] Specifically, the right for the Asylums Committee of the LCC to *pay* for the treatment of voluntary patients under the LCC (Parks &c) Act of 1915, extending to the Maudsley 'a privilege at the time granted only to licensed houses and registered hospitals.'[80]

Key to the Maudsley's therapeutic outlook is the strategy of early intervention. Rhodri Hayward demonstrates that this position owes much to the influence of German psychiatry.[81] Edgar Jones and Shahina Rahman note that '[u]nder the terms of Henry Maudsley's endowment, the hospital was committed to "the early treatment of cases of acute mental disorder, with the view as far as possible, to prevent the necessity of sending them to the county asylums."'[82] The hospital is also characterized by a therapeutic scepticism which means that patients are 'shielded from the worst excesses of optimistic psychiatry',[83] much to the chagrin of William Sargant who later recalls that the Medical Superintendent, Edward Mapother 'feared to risk the lives of voluntary [patients], especially with our fierce local coroner ready to pounce on us at the slightest provocation.'[84] This modesty in treatment is mirrored by theoretical restraint, what Hayward calls an 'epistemological skepticism [which] was to become the defining feature of the Maudsley in the interwar years… [with] stress on modesty and respect for pathological complexity'.[85] Thanks to funding from the Rockefeller Foundation and the arrival in 1935-36 of famous German émigrés,[86] the Maudsley achieves a

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[77] R. Hayward, "Germany and the Making of "English" Psychiatry," in *International Relations in Psychiatry: Britain, Germany, and the United States to World War Ii*, ed. V. Roelcke, P. Weindling, and L. Westwood (Rochester, NY: University of Rochester Press, 2010), p.68.

[78] Jones, Rahman, and Woolven, "Design and Strategic Direction," p.363.

[79] Ibid.

[80] Ibid.

[81] Hayward, "Germany and "English" Psychiatry," pp.67-68. Ideas around early intervention and integration between psychiatric and general medicine are first articulated by German psychiatrist Wilhelm Griesinger in the mid-to-late nineteenth century. E.J. Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (New York: Cornell University Press, 2003). Thanks to Åsa Jansson for references and discussions of Griesinger's ideas.

[82] E. Jones and S. Rahman, "Framing Mental Illness, 1923–1939: The Maudsley Hospital and Its Patients," *Social History of Medicine* 21, no.1 (2008): p.108.

[83] Ibid.: pp.123-124.

[84] Sargant quoted in Jones, Rahman, and Woolven, "Design and Strategic Direction," p.378.

[85] Hayward, "Germany and "English" Psychiatry," p.77.

[86] Jones, Rahman, and Woolven, "Design and Strategic Direction," p.374.

pre-eminent position in the postgraduate teaching of Psychiatry in Britain, reinforced in 1948 with the founding of the Institute of Psychiatry under Aubrey Lewis.

Observation and treatment: 'clearing', diagnostic 'mixing' and links to 'the social'

In contrast, during the inter-war period, observation ward patients are *not* voluntary, but they are temporary.[87] Patients are usually detained for an initial three days (under the Relieving Officer's three-day order); before this period expires a Magistrate is required to see the patient (under Section 20 (4) of the Lunacy Act). Detention normally continues for a further fourteen days, under the Medical Officer's Certificate (Section 24 (1 and 2) of the Lunacy Act).[88] After this combined period of seventeen days the patient is usually either sufficiently recovered to be discharged, or needs to be transferred, whether voluntarily or involuntarily to a psychiatric hospital. Any interaction between therapeutic regimes at a general hospital is severely time limited for individual patients. In 1940 it is commented that the fourteen-day assessment period constitutes the *raison d'être* of an observation unit.[89] This established function as 'clearing stations' for diagnosis and disposal is augmented with a growing (though contested) *treatment* role, marking it out as a key boundary space between two therapeutic regimes. These types of 'clearing' spaces also have significant links to a socially-focused psychiatric gaze, in military and other settings. Potential for psychiatric scrutiny connected to general hospitals increases, whilst their 'secure' nature is another factor in the continuing association with 'attempted suicide'.

The changes in these wards are uneven. Pentreath and Dax show how far observation wards are in flux during the 1930s, arguing that '[o]bservation wards are still in their infancy so far as their developmental possibilities are concerned – in fact *we are still in the process of deciding what their purpose should be*.'[90] Mapother's Maudsley Hospital Superintendent's Report (1932-35) observes that 'the rising prestige of mental observation wards is producing great changes'.[91] The diagnostic function seems agreed in the 1930s; there is significantly more uncertainty about what *else* might be attempted in observation wards. Treatment is at the centre of the changes. Pentreath and Dax quote a Board of Control Report for 1935 which advises that '[o]nce it has been established that a patient requires treatment for mental illness, no time should be lost in transferring him to the mental hospital, which in general is the *only place* able to provide the specialized experience and the therapeutic resources necessary

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[87] '[A]dmission to the Wards must be effected by the Relieving Officer.' Lewis and Calder 'General Report' p.6.
[88] Lewis and Calder 'General Report' (1938) pp.3-5. See also V. Norris, *Mental Illness in London* (London: Chapman & Hall, 1959).
[89] Butler, "Observation Units," p.726.
[90] Pentreath and Dax, "Observation Wards," p.362. Emphasis added.
[91] Quoted in Ibid.: p.361.

for successful treatment'.[92] The report further states that '[e]very improvement of the observation wards increases the temptation to undertake *active treatment*, a practice *quite inconsistent with the main purpose of such wards*, which is the diagnosis of doubtful cases.'[93] The Board of Control is clear: mental treatment must take place in a mental hospital, and only there; observation wards are diagnostic clearing stations and gateways to the more remote mental hospitals.

In one sense, this effort to keep mental treatment solely within mental hospitals enforces the separation of psychiatric and general medicine. However, emphasising their role in diagnostic 'clearing' necessitates some sort of psychological scrutiny. As Skottowe comments during a discussion of St Francis' observation unit '[i]t is impossible to divorce investigation from treatment. Investigation *is* treatment – as those who deal exclusively with psychoneuroses constantly emphasize.'[94] Any attempt to restrict treatment entirely is undercut by the provision of psychiatric diagnostics. The wards function as a diagnostic gateway: Dunkley and Lewis recall 'a tendency to regard them [observation wards] as psychiatric casualty-clearing stations'.[95] Frederick Hopkins shows that his Liverpool observation wards function like this in 1943, noting that 'except with those individuals – a small proportion – whose means allow of private care, or in cases in which voluntary admission to county mental hospitals is arranged direct, such persons must in the first place go into a mental observation ward.'[96]

The military language of 'clearing station' is significant, given the established links between the First and Second World Wars and the wider acceptance of psychiatric techniques.[97] The term 'clearing-hospital' first appears (according to the *Oxford English Dictionary*) in the *Lancet* in 1914. The term 'clearing-station' (deemed equivalent) appears in 1915. The former term has a history before the First World War: an article entitled 'The Casualty Clearing Station' states in 1917 that '[p]rior to the present war, this unit [casualty clearing station] was designated a "clearing hospital"; but the nomenclature was altered to "casualty clearing station" soon after the commencement of the present campaign [WWI].'[98] Casualty clearing stations come to prominence during the 1914-1918 war, but it is in the Second World War that frontline psychiatric treatment is carried out in them.

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[92] Ibid.: p.348. Emphasis added.
[93] Ibid.: pp.348-349. Emphases added.
[94] Skottowe, "Discussion," p.732. Original emphasis.
[95] E.W. Dunkley and E. Lewis, "North Wing: A Psychiatric Unit in a General Hospital," *The Lancet* 281, no.7273 (1963): p.156.
[96] Hopkins, "Admissions," p.358.
[97] See e.g. J. Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (London: Reaktion Books, 1996); Shephard, *War of Nerves*.
[98] It is also stated that '[t]he unit corresponds, more or less closely, in organization, establishment and function to the "evacuation hospital" of the United States Army.' T.H. Goodwin, "The Casualty Clearing Stations," *Journal of the American Medical Association* 69, no.8 (1917): p.636.

There is also a non-military parallel, with David Armstrong's term 'dispensary' (see introduction) which is his shorthand for 'a new way of *seeing* illness... [in which] the dispensary radiated out into the community.'[99] He argues that '[t]he dispensary was a receiving house and a centre of diagnosis... a clearing house and a centre for observation... a treatment centre'.[100] The functions of diagnosis, treatment and observation all feature in debates around observation wards. Given Armstrong's compelling argument that it is the 'gaze of the dispensary' that undergirds the project of community-focussed, social medicine, the emergence of a clinical 'attempted suicide' similarly rooted in social environments and relationships – in the 'interstices of relationships' as he would have it – is of considerable importance.[101]

Observation wards are clearly implicated in the negotiation between psychiatric and somatic medicine through the Board of Control's strictures against mental treatment but endorsement of diagnostics (which must be significantly 'mixed' in order to be effective), but also in various practices linked to the rise of socially-focused mental medicine through military terminology and similarity with the 'dispensary'. This is not all, as Pentreath and Dax come out explicitly against the Board of Control's sentiment, claiming that 'in certain cases, active treatment... is to be encouraged, and that in fairness to the patient, it should be practised whilst the diagnosis of difficult cases is proceeding'.[102] For them, it is 'one of the first principles of disposal not to transfer a patient to a mental hospital if it could be avoided.'[103] So as well as mixed *diagnostics*, the ward provides active mental *therapeutics* connected to a general hospital. As 'treatment' is a more involved form of scrutiny or practice than simply 'diagnosis', the level of psychological scrutiny in these wards is – unevenly – increasing.

Lewis and Calder's *findings* in 1938 are more in tune with the Board's wishes, observing that 'these observation units function largely, if not solely, as clearing stations',[104] but a sense of this debate does surface with treatment seen more as an unreasonable expectation rather than unwelcome in itself: 'we should not expect to find much provision made for the treatment of mental illness in these wards... [b]earing in mind the restricted purpose served by these observation wards'. Although they find that '[i]n none of the wards did we find any attempt at prolonged treatment of the patients', the operative word is 'prolonged'; they visit

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[99] Armstrong, *Political Anatomy*, pp.7-8.
[100] Ibid., p.7.
[101] This connection is illustrative and rather speculative, but perhaps points the way to more research upon the connections between the function of 'sorting' and a more psychosocially-focused outlook.
[102] Pentreath and Dax, "Observation Wards," p.362.
[103] Ibid.: p.352.
[104] Lewis and Calder 'General Report' p.6

St. Francis and quote Pentreath and Dax's paper in their report.[105] It should not be forgotten –
at the London wards explicitly – that psychiatrists who worked at the Maudsley also worked at
some observation wards,[106] especially the regular visits to St. Francis' first by Mapother and
then by Lewis.[107] Pentreath and Dax are aware of the special circumstances surrounding St
Francis, admitting that '[f]ew observation wards in other counties have consultant
psychiatrists, officers and staff experienced in mental diseases, and all prognostic aids.'[108] In
addition, Hugh Freeman notes that even though 'by the late 1930s, only one teaching hospital
had a psychiatric ward... some observation wards began to treat acute patients'.[109] Perhaps
this is why Lewis and Calder end the report with a clear response to the debate: '[t]he fact we
wish to urge is that the observation wards as organised at present cannot be said to cater for
the treatment of large numbers of mild and early cases of mental illness that remain in the
community.'[110] The potential link with 'the social' or 'community' emerges explicitly, and a
'clearing station' is an almost archetypal liminal space, with connections to mental and general
hospitals.

Legality, safety and restraint: 'attempted suicide' associations

At the Maudsley, the voluntary status of all patients brings constraints of its own in terms of
treatment and administration. As part of the therapeutic cautiousness mentioned above, 'the
range of treatments and management techniques available to the medical staff was
reduced'.[111] However, as Jones, Rahman and Woolven argue, a large part of Mapother's
reluctance to 'sanction cardiazol fits, lobotomy and insulin coma therapy' is not just because
these are considered 'intrusive, unpleasant and dangerous' but due to his fear that, under no
compulsion to remain, 'patients would vote with their feet.'[112]

Whilst voluntary status places an informal limit on some treatment options, other practices,
such as 'mechanical restraint' are illegal. These rules allow the hospital 'to exclude unruly and
chronic patients'.[113] It is suggested in 1926 that Mapother's view that 'no clinical basis could be
found to justify the distinction between the neuroses and psychoses... was a justification for
the Maudsley's admissions policy, which effectively blocked chronic cases of severe mental

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[105] Ibid.: p.16. Pentreath & Dax's article is quoted at length on p.14.
[106] E.g. W. H. Trethowan recalls that whilst at the Maudsley (1948-1950), 'I was also in charge of the Observation Ward at St. Francis for a short time as a locum.' Wilkinson, *Talking*, p.30.
[107] The exact timing of these visits is not clear; that the visits were regular is not disputed. See Mayou, "General Hospital Psychiatry," p.768; Wilkinson, *Talking*, p.138.
[108] Pentreath and Dax, "Observation Wards," p.363.
[109] H.L. Freeman, "The General Hospital and Mental Health Care: A British Perspective," *The Milbank Quarterly* 73, no.4 (1995): p.655. See Chapter five.
[110] Lewis and Calder 'General Report' p.21.
[111] Jones, Rahman, and Woolven, "Design and Strategic Direction," p.377.
[112] Ibid.: p.378.
[113] Jones and Rahman, "Framing Mental Illness," p.109.

illness.'[114] Whilst this is simplistic, Mapother's public position that 'the nosological division between psychotic and neurotic disorders was merely a legal one relating to the issue of certification'[115] brings into sharp focus the relationship between legal classification and psychiatric nosology. The Maudsley is not legally permitted to restrain patients in certain ways due to the hospital's voluntary status; this feeds into an admissions policy producing a patient population of minor neurotics and depressives. Unruly, dangerous or chronic patients are largely conspicuous by their absence.[116]

The use at the Maudsley of nets over cots with padded sides – preventing restless or noisy patients from sitting up in bed – provokes in the late 1930s 'a formal complaint by the Board of Control that they [the nets] breached the hospital's legal guidelines' because '[b]y definition, voluntary patients could not be restrained by mechanical means'.[117] It is this situation that prompts Lewis and Calder's report on observation wards in order 'to ascertain how far netted beds are used in these wards and for what types of patient.'[118] It is hoped that observation ward practice might shed some light on the legality of the situation at the Maudsley. Their conclusion on the matter (for *observation wards*) is that whilst 'it would be unadvisable to make any regulation forbidding the use of nets in any circumstances... we would urge that their use should, in future, be regarded as a form of mechanical restraint to which all the rules relating to this form of control already recognised by the Board should apply.'[119] Thus the recommendation seeks to prohibit them at the Maudsley. Mechanical restraint is illegal for the Maudsley's voluntary population, but observation wards are significantly associated with it in some form. This is implied by the above: a 'General Report on the Observation Wards' only makes sense as a response to concerns over restraining patients if these wards are significantly associated with restraint, or as dealing in other ways with potentially 'unruly' patients. The *potential* use of 'restraint' or 'seclusion' (in a padded room) has an impact upon the referral of patients considered 'dangerous' (either 'to themselves' or others), regardless of how often such techniques are used. This is a key difference between the Maudsley and the London observation wards for the emergence of attempted suicide, relying upon the truism that 'attempted suicides' are 'dangers to themselves'.[120]

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[114] Ibid.: p.107.

[115] Ibid.: p.114.

[116] Sidney Crown recalls that post-1945 at the Maudsley, one could 'transfer ("get rid of") troublesome patients at the drop of a hat or at least following a polite request on the telephone.' S. Crown, "Post-War Maudsley Personalities," *Psychiatric Bulletin* 12, no.7 (1988): p.265.

[117] Jones, Rahman, and Woolven, "Design and Strategic Direction," p.368.

[118] Minute to SECRETARY [p.1] , TNA: PRO: MH 95/32.

[119] Lewis and Calder 'General Report' p.16.

[120] Something that endures today: 'More often than not, however, dangerousness presents in the form of people being a danger to themselves, through suicide or deliberate self-harm.' Mind, 'Dangerousness

The observation ward's significant role with 'dangerous patients' has a history; a *Lancet* editorial from the 1930s characterises observation wards as a place for 'acute and dangerous mental illness'.[121] It is also associated as having a role in the control of 'violence' in 'would-be suicides' in its incarnation as a workhouse mental block. Pentreath and Dax note in the late 1930s that one of the functions of the St Francis Ward was 'to secure the safe custody of patients pending their admission' to a mental hospital.[122] This role of providing 'safe custody' persists after the war. In 1954, Edinburgh consultant John Marshall argues that '[e]very general hospital group should have a psychiatric service with out-patient clinics, in-patient beds for suitable cases, and *an observation unit for disturbed patients*'[123] suggesting a significant 'control' function.

Anxieties on the part of medical practitioners contribute to the referral of 'attempted suicides' to a more 'secure' environment (and the observation ward figures doubly, providing that environment in itself, and as a gateway to the more 'secure' mental hospital). As seen above, observation wards have associations with 'attempted suicide'; concerns over safety, dangerousness and restraint form a significant part of that association. This is not to say that 'attempted suicides' are the only patients for whom restraint is thought necessary – far from it. This argument is that the potential for restraint and safety at an observation ward makes it more likely for attempted suicide to become associated with such wards during this period. This differentiates the observation wards from the Maudsley, where in order 'to exclude "altogether unsatisfactory" patients, those who might require physical restraint or sedation against their will, the [hospital] did not offer an emergency service.'[124]

Two of the initial options for mental treatment in London have been sketched out. These institutions have different roots, different legal obligations and different attitudes towards treatment. At the Maudsley, founded for the purpose of early intervention into mental disorder, the population is all voluntary and patients are largely treated non-invasively and by

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and Mental Health: The Facts' *Mind Factsheet* http://www.mind.org.uk/help/research_and_policy/dangerousness_and_mental_health_the_facts accessed 16.09.2011. 'Dangerousness' is increasingly replaced by 'risk' concerns by the late twentieth century. R. Castel, "From Dangerousness to Risk," in *The Foucault Effect: Studies in Governmentality*, ed. G. Burchell, C. Gordon, and P. Miller (Chicago: Unversity of Chicago Press, 1991). N. Rose, "Governing Risky Individuals: The Role of Psychiatry in New Regimes of Control," *Psychiatry, psychology and law* 5, no.2 (1998).

[121] Quoted in R.P. Snaith and S. Jacobson, "The Observation Ward and the Psychiatric Emergency," *The British Journal of Psychiatry* 111, no.470 (1965): p.18.

[122] Pentreath and Dax, "Observation Wards," pp.347, 349.

[123] J. Marshall, "Mental Health Services," *British Medical Journal* 2, no.4902 (1954): p.1484. Emphasis added.

[124] Jones, Rahman, and Woolven, "Design and Strategic Direction," p.364. quoting LMA Report of the Asylums and Mental Deficiency Committee, 27.06.1922. However, in 1931, a separate villa 'was constructed in the gardens to house patients who were willing to be treated but who were difficult to manage.' ———, "Design and Strategic Direction," p.368.

consent with a view to eventual recovery, if not cure. In observation wards, patients are compulsorily admitted for up to seventeen days so that diagnosis can occur, and the appropriateness of mental hospital admission can be ascertained; formal treatment is discouraged, but sometimes carried out regardless. Interwar observation wards can be characterised in terms of diagnosis, treatment and security. The diagnostic, 'clearing' function marks it out as a boundary space between therapeutic regimes, and the rise of mental treatment (being a more intense form of psychological scrutiny than mere diagnostic sorting) further enhances the therapeutic liminality of this general hospital-based ward. These 'mixed' clearing stations have an obscure but striking relationship with a more socially-focussed psychological outlook, in both military and non-military terms. 'Attempted suicide' emerges in boundary disputes due to the co-incidence of mental and somatic concerns, reinforced by the secure provisions around mental therapeutics.

This chapter ends with analysis of possibly the only dedicated 'attempted suicide' study in England and Wales pre-WWII. Whilst Erwin Stengel's work throughout the 1950s at observation wards is acknowledged as central in the twentieth-century rearticulation of 'attempted suicide' (and is analysed closely in the following chapter) the first study of 'attempted suicide' to emerge after the 1929 reorganisations and abolition of the poor law in England and Wales is published in 1937 by Frederick Hopkins at Smithdown Road Hospital, Liverpool. This psychiatric-epidemiological object 'attempted suicide' is fundamentally linked to conditions obtaining at observation wards, principally their mixed therapeutics / diagnostics and secure nature.

Frederick Hopkins (1937, 1943)

Hopkins is rather obscure, but has an interest in child guidance (co-authoring an article on parental loss with Muriel Barton Hall[125]) and a lecture series is established in his name in 1968.[126] His work is mentioned above, describing three popular classes of patient (including 'attempted suicide') that pass through his ex-workhouse observation ward at Smithdown Road (Liverpool) during the Second World War. His 1937 study 'Attempted Suicide: An Investigation' is based at this ward, which opens in 1909 to care for 'harmless, chronic, or temporarily affected patients who would otherwise be in the county asylums.'[127]

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[125] Hall also authors *The Psychiatric Examination of the School Child* (1947). M.B. Hall and F. Hopkins, "Parental Loss and Child Guidance," *Archives of Disease in Childhood* 11, no.64 (1936). See chapter two for links between child guidance and psychiatric social work.

[126] I. Leveson, "Evolution of Psychiatry in a Clinician's Lifetime," *Transactions and Report / Liverpool Medical Institution* (1968).

[127] University of Liverpool – Division of Psychiatry 'Psychiatry in Liverpool: 20th Century' http://www.liv.ac.uk/psychiatry/history/20th.htm accessed 22.07.2012.

Hopkins relates that '[p]rovision for the observation of cases of mental disturbance [is made in a] large general hospital [with] two special divisions'. He emphasises that 'to the wards of these divisions are receivable all cases of attempted suicide occurring in Liverpool'.[128] The association of these special wards with 'attempted suicide' – partially through the availability of 'temporary care under detention orders' – is made explicit. It has already been noted that in 1920 Liverpool Police judge the workhouse infirmary especially suited for 'attempted suicides' as 'there are qualified persons' there.[129] This is clearly related to the secure nature: '[a] great majority of persons whose mental condition or behaviour demands restraint and /or supervision must be admitted to suitable institutional care' and the majority of these 'must in the first place go into a mental observation ward.'[130] He states '[t]he majority of cases were admitted to the hospital under Section 20 of the Lunacy Act, the Temporary Detention Order being completed by the appropriate relieving officer or a police-constable.'[131]

It is noted that the observation ward does not quite have the general medical facilities to deal with emergencies, but links with acute somatic care are maintained through *transfer*: '[s]evere and urgent cases [of attempted suicide] may be admitted to the nearest hospital, but a large proportion of these, if they survive, are transferred [to the observation ward] when able to be moved.'[132] However, the severest emergencies aside, the emergence of 'attempted suicide' is linked to the crossover of psychic and somatic therapeutics in this space. As has been quoted above, Hopkins claims that 'attempted suicide' is one of three 'fairly common reasons for admission'.[133] It is significant that G.P.I. (since the Wasserman test) and epilepsy (the other two reasons) are among the most securely somaticised mental disorders of the period.[134] There is also a sense that both G.P.I. patients and epileptics have the potential to be disruptive and/or violent.[135] These two illness categories perform a very different negotiation between psychic and somatic medicine to 'attempted suicide', showing that there is nothing fixed or inevitable about such broad differentiations as between 'psyche' and 'soma'.

As noted, the rise of treatment in observation wards heralds a more intense type of psychological scrutiny. However, the treatment role is highly ambiguous at Smithdown Road:

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[128] Hopkins, "Attempted Suicide," p.71.
[129] Letter from Chief Constable of Liverpool to Home Office dated 21.10.1920.
[130] Hopkins, "Admissions," p.358.
[131] ———, "Attempted Suicide," p.79.
[132] Ibid.: p.71.
[133] ———, "Admissions," p.358.
[134] Hopkins notes in 1937 that 'a Wassermann test of the blood is made in all patients admitted to the special divisions of the hospital.' ———, "Attempted Suicide," p.82.
[135] A 1960s psychiatric textbook mentions previously widely-held views that all GPI cases exhibit 'expansive euphoria' and 'foolish elation'. Also mentioned are 'acute delirious states which may follow an epileptic fit... Violent and unrestrained behaviour (the epileptic furor) is well documented by extremely rare.' Merskey and Tonge, *Psychiatric Illness*, pp.85, 225-226.

'[i]n hospital, under conditions sheltered from ordinary life they [patients] can take a more objective view. They are enabled to discuss and disentangle their mental complexities, and there is an opportunity for readjustment with relatives and associates.'[136] Hopkins is open about the therapeutic *effects* that occur in observation wards, without actively carrying out treatment.

Similarly, the intensity of the scrutiny he brings to bear on these 'attempted suicide' patients is somewhat unclear. His study is undertaken 'to discover the factors which had led to such ['attempted suicide'] action.'[137] He initially states that '[t]he material and social conditions are known or easily investigated, and relatives, friends, relieving officers, police and probation officers are usually available to provide information.'[138] However, he then changes tack, conceding that '[s]uch an enquiry obviously entails a great deal of work in the detailed investigation of each patient, the interviewing of relatives, friends and other informants.'[139] In a 1930s observation ward, with limited opportunities for psychiatric scrutiny, he reveals that it 'was decided to limit the number to 100 cases, taking 50 consecutive admissions of each sex' and that '[n]o effort is made to consider... its psychological mechanisms'.[140] For Hopkins, 'a real and complete understanding of the causes for such action would necessitate so prolonged and detailed a study of the individual as is impossible in practice.'[141] In remarkably explicit terms, Hopkins argues that a study of the 'psychological mechanisms' behind attempted suicide requires 'a great deal of work' and 'detailed investigation' – something that is just not possible in these wards at the time.

'Attempted suicides' are seen as a distinct clinical entity, though perhaps more due to the secure nature of the wards. However, Hopkins assumes that 'psychological mechanisms' do indeed exist, even if he has no time or resources to study them in-depth. This psychologically-based assumption translates into something rather similar to a 'cry-for-help' object in these observation wards, but it is notable how cautious Hopkins is when describing it:

> 'It might be contended, and with reason, that in investigating a consecutive series
> of cases admitted to hospital on account of attempted suicide, one may be
> dealing not solely with cases who have attempted self-destruction, but also with a
> proportion whose motive was essentially different, viz., to produce a similar effect
> in order to gain personal ends. That is to say, there may be cases whose actions

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[136] Hopkins, "Attempted Suicide," p.93.
[137] Ibid.: p.71.
[138] Ibid.
[139] Ibid.: pp.71-72.
[140] Ibid.: p.72.
[141] Ibid.: pp.84-85.

are essentially hysterical, or comparable to the self-infliction of disabling wounds. A decision on this point, especially after the event, is always a difficult one'.[142]

The transformations that are already happening in observation wards (having a consulting psychiatrist such as Hopkins on the wards, for example) bring sophisticated psychiatric scrutiny to bear upon, and reconstitute, 'attempted suicide'.

He mentions a certain kind of poisoning: 'coal-gas poisoning is by far the most common method, in females accounting for nearly 70% of all suicides'[143] and that 'coal-gas poisoning is the commonest method with both sexes'.[144] He sees poisoning *in general* as associated with predominantly 'demonstrative' attempts:

> 'The small number of poisoning cases that it was found necessary to send to mental hospital compares in striking fashion with the large percentage of what might be called the more violent methods... It may be that in this [poisoning] group there are many whose attempt has been more of the nature of a demonstration than a serious attempt at suicide.'[145]

However, he remains aware of his research limitations when appraising the general view 'that suicidal attempts by women are commonly of the demonstrative, attention-seeking kind, without real intent to terminate life.'[146] He is again cautious and equivocal, arguing that '[t]here may be justification for this view, but this investigation has shown that women are little less determined than are men.'[147] Hopkins judges his research resources and opportunities too meagre to firmly establish a phenomenon or to generalize it. This is not to say that levels of intensity correspond precisely to various characteristics of different research objects, but that a relationship does obtain between research objects and the level of scrutiny that produces them. This seems a significant engagement with the gender dynamic that appears so strongly in the textbooks, differentiating the 'attempted' from 'consummated' suicide populations, but Hopkins has a gendered reason of his own: '[i]mpulsiveness, lack of knowledge and preparation result in fewer fatal endings to their [women's] attempts'.[148] Hopkins' gendering is achieved on the basis of 'impulsiveness' and 'ignorance' rather than gendered *intent* (although he acknowledges that the 'intent' argument has been made).

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[142] Ibid.: p.85.
[143] Ibid.: p.76.
[144] Ibid.: p.77.
[145] Ibid.: p.78.
[146] Ibid.: p.91.
[147] Ibid.
[148] Ibid.

He again mentions the effort that has gone in to his series: 'the effort was made to discover not only the reasons why the patient decided to attempt self-destruction, but also the circumstances which had led up to such a reaction.'[149] One of his key findings involves the term 'domestic stress' which

> 'is somewhat vague, but is meant to include such circumstances as deaths in the family, quarrels and disharmony on various accounts, such as religion, inconstancy, maintenance, etc. It is not surprising that the numbers under this heading should be comparatively large when the emotional relationships of family life have so many aspects. As might be expected, the effects were more frequent in women, because to women life as a rule is focused domestically.'[150]

He also notes 'that up to the age of 25 female cases are very numerous, being twice the total of males. This, no doubt, is due to the hazards of love affairs and of early married life, misfortunes in these circumstances bearing more hardly on the female.'[151] Thus a domestic-romantic 'social constellation' is projected from an observation ward, in order to explain an 'attempted suicide'. This socially-focussed explanation is clearly linked to psychological notions of 'stress', which Hopkins and Hall deploy in their child guidance article. Whilst there are no differences in *personality* between children from 'normal' and 'disturbed' homes, 'there are circumstances in the disturbed home environment and possibilities of difficulty or stress for the child which may lead to the production of symptoms.'[152]

This domestic 'social constellation' deployed around Hopkins' object is very much present-focussed. It is part of what he calls 'precipitating causes'. These include 'mental disorder' (where 'the immediate cause of the action was the abnormal state of the patient's mind'), as well as '[d]omestic stress' '[b]usiness or economic stress', '[a]lcohol' or '[a]matory disturbances'.[153] However, these exist in constant negotiation with much longer-term 'conditioning causes' which 'include characteristics of personality showing definite deviation from the normal (or average), and physical states which were the primary cause of changes in the mental attitude'.[154] These more 'background' long term factors are considered inaccessible: '[n]o effort has been made to investigate their origins'.[155] However, Hopkins is

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[149] Ibid.: p.85.
[150] Ibid.: p.86.
[151] Ibid.: p.90.
[152] Hall and Hopkins, "Parental Loss," p.193-194.
[153] Hopkins, "Attempted Suicide," pp.85-86.
[154] Ibid.: p.85.
[155] Ibid.

clearly aware of their import, again through his work in child guidance.[156] This interplay between past and present factors, either in the social environment, affecting intent, or in broader domains of aetiology in 'attempted suicide' is continually reconstituted and reconfigured by different psychiatric workers during the 1950s and 1960s. Principally, the shift occurs between those emphasising the aetiological significance of childhood emotional trauma, and those focussed upon current domestic stress and marital pathology.

Concluding thoughts

Hopkins' socially situated object is very different to the financial disputes of 'police watching', perhaps because the latter arguments are broadly concerned (on the medical side) to exclude 'attempted suicide' as unsuitable, whereas Hopkins accepts it as commonplace, with a referral arrangement in place if any given case of 'attempted suicide' is considered gravely physically injured. Hopkins is thus able to aggregate psychiatric evaluations of patients whose injuries require urgent physical treatment in the first instance. The 'secure' nature of the ward also encourages referral of 'attempted suicides' who had technically committed a crime, as well as being thought dangerous to themselves. There is also the question of growing psychological scrutiny through *treatment*, at sites attached to general hospitals, although Hopkins' research resources are still rather meagre.

In the Ashton inquest the 'essence' of 'attempted suicide' as either 'psychic' *or* 'somatic' is debated, corresponding to therapeutic regimes so separate that they are a 'joy ride' apart. After the reorganisations of 1929-1930 a different context obtains. Along with the secure nature of observation wards the key contextual factor in 'attempted suicide' is its position *between* the two distinct regimes of mental and general medicine. These are broadly contained in the mixed diagnostic/therapeutic environment of an observation ward, but are also augmented by referral practices mentioned briefly by Hopkins. The battles fought around 'attempted suicide' centrally concern this secure and liminal therapeutic space, reconstituting 'attempted suicide' as an object for scrutiny. This liminality within general hospitals remains the focus after 1948.

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[156] Hopkins and Hall characterise the 'disturbed' or 'broken home' as 'a medley of facts and circumstances, decisive in their origin, but diffuse in their manifestations and extensive in their effects.' Hall and Hopkins, "Parental Loss," p.194.

Chapter 2: The NHS, psychiatric social work and high-intensity psychosocial scrutiny (1948-1958)

The establishment of the National Health Service (NHS) towers over the immediate post-war period in Britain, a monumental effort (in times of severe financial austerity) to achieve what its principal architect Aneurin Bevan later called 'pure socialism'.[1] The enormous significance of the NHS extends to its impact upon psychiatry. Charles Webster, official historian of the NHS, declares that its inception 'marked one of the major organisational turning points in the history of mental health services reform' and compares it to the development of county lunatic asylums 100 years previously.[2] The inclusion of mental health within the comprehensive service enables closer cooperation and referral between the fields of mental and general medicine, vital for the visibility of 'attempted suicide as a cry for help'.

NHS *funding* removes the financial and 'therapeutic suitability' concerns over 'attempted suicide' seen around voluntary hospitals in the previous chapter. This enables cases to be almost universally admitted to general hospital casualty departments. The *integration* effected by the NHS means that these departments assume a coordinating function. Continuing as places for acute care, they become a gateway to the varied specialisms of hospital medicine (surgery, urology, etc.). Their position as acute, non-specialist, diagnostic departments means that despite the removal of financial or therapeutic dispute, the object of 'attempted suicide as a cry for help' does not emerge consistently here. There is no sustained psychological scrutiny or follow-up which are necessary for this particular clinical object to materialise. Thus there are two parts to the emergence of 'attempted suicide': a path between different therapeutic regimes or a space that can encompass them both, and the possibility for sustained, high-intensity psychiatric scrutiny to construct an environment necessary for a 'cry for help'. This 'environment' is crucial to complex intent, shifting it from 'death' by opening up 'communication'.

The 'environmental scrutiny' is bound up with child guidance (as hinted in the previous chapter), and especially psychiatric social work. One consequence of the NHS is a more consistent focus upon the environment, and the health of children. A short film about changes to healthcare in 1948 states that 'the local council will have a new duty to provide home nursing, health visiting, and home help services... maternity and child welfare services will be

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[1] A. Bevan, *In Place of Fear* (London: William Heinemann, 1952), p.106.
[2] C. Webster, "Psychiatry and the Early National Health Service: The Role of the Mental Health Standing Advisory Committee," in *150 Years of British Psychiatry, 1841-1991*, ed. H. Freeman and G. E. Berrios (London: Gaskell, 1991), p.104.

improved'.[3] Concern about children is also expressed in the burgeoning popularity of John Bowlby's theories of maternal attachment, which form the basis for influential series of 'attempted suicide' studies in the early fifties.

These are carried out in Edinburgh between 1951 and 1955 in an observation ward with different historical roots to those of the workhouse mental block. This Ward for Incidental Delirium (known colloquially as 'Ward 3') has much less focus on security and restraint, and more of an entrenched somatic medical focus – specifically around poisoning. The studies carried out in Ward 3 are significant because their findings are underpinned by collaboration between a psychiatrist (Ivor Batchelor) and psychiatric social worker (PSW) (Margaret Napier). PSWs have significant associations with observation wards and emerge from the 'child guidance' movement. The initial transformation that enables a 'cry for help' around a case of 'attempted suicide' is due to institutional factors and mixed therapeutics (as well as much older stereotypes). 'Physical injury' is transformed by the investigative practices emerging from this collaborative effort, such as home visiting and follow-up interviewing. The history of PSWs is covered in detail below.

Alongside these studies are a number of contributions by Erwin Stengel, both by himself and in collaboration with a PSW (Nancy Cook) and a psychiatric registrar (Irving Kreeger), including the seminal *Attempted Suicide* (1958). The practice of referral to observation wards is prominent in Stengel's work, as is follow-up interviewing, showing clearly that the transformations effected through transfer between acute somatic care and psychological investigation are further developed by PSW practice. 'Attempted suicide' is still significantly associated with the 'restraint' and 'security' of observation wards. However, for both collaborations, the NHS facilitates movement between different therapeutic approaches, whilst PSWs and psychiatrists converge upon this object, further transforming it into a credible expression of interpersonal disturbance.

Broader concerns about the young are articulated in 'moral panics' over 'Teddy Boys' and 'rock 'n' roll' during the 1950s, more famous landmarks of 1950s cultural history than 'attempted suicide',[4] but focused upon that same 'problem group': adolescents and young adults. The rise of psychiatric social work from inter-war child guidance clinics helps to explain a focus upon childhood home environments as fostering psychopathology or more general deviance. Also, in 1953 the Reverend Chad Varah establishes a service from his London vicarage for people 'in

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[3]   Department   of   Health   'Your   very   good   health'   (1948) http://www.nhs.uk/Livewell/NHS60/Pages/VideointroducingthenewNHS.aspx accessed 11.07.2012.
[4] For the classic statement of 'moral panics' see S. Cohen, *Folk Devils and Moral Panics: The Creation of the Mods and Rockers* (London: MacGibbon & Kee, 1972).

distress who need spiritual aid' and a '999 for the suicidal'. The Daily Mirror coins the term 'Telephone Good Samaritans' for the service and it sticks.[5] Concern about the mental, physical and moral state of young people, and about suicide, distress and despair is circulating throughout the 1950s, a decade overshadowed on either side by the Second World War and the 'swinging' sixties, but exceptionally important for the entrenchment of 'attempted suicide as a cry for help'.

The NHS and psychological scrutiny during the 1940 and 1950s

The NHS brings different specialist outlooks into a new, more connected relationship with each other. In the case of psychiatry, the Board of Control is brought into the NHS, having unsuccessfully pushed for a separate administrative mental healthcare structure.[6] Thus the potential for crossover is *much more widely available* than simply focussed upon observation wards. A new combination of specialisms brings new clinical objects into being, and observation wards continue to play a central role in the 1950s. The NHS is also the first step in *broadening* the new field combining acute-physical and psycho-social visibility on a *national* scale. The NHS casualty departments cannot quite achieve this alone, but there are important steps towards national visibility and an 'epidemic'.[7]

The establishment of the NHS is widely viewed as an important step in the integration of psychological and general medicine. Walter Maclay and epidemiological psychiatrist John Wing both cast the founding of the NHS as an intermediate stage between 'separated' and 'integrated' mental and general medicine (a position that shares much with the present account).[8] The end point of this process (for Maclay at least) is the Mental Health Act 1959, covered in chapter three. Webster sees the NHS as more of a culmination than a staging-post, claiming that it 'marked the end of a 25-year campaign to end the separate administration of mental health services'. Whilst that is arguable, he is correct in his claim that '"isolation" was thought to have impeded progress. "Integration" was seen as the key to modernisation'[9]

In 1947, after the passing of the NHS Act but before the 'appointed day' of inauguration in 1948, clinicians at the Withington Hospital in Manchester relate the appointment of 'a visiting

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[5] Samaritans, 'Samaritans History' http://www.samaritans.org/about_samaritans/governance_and_history/samaritans_history.aspx accessed 11.07.2012.

[6] Mayou, "General Hospital Psychiatry," p.770. See also C Webster, "Conflict and Consensus: Explaining the British Health Service," *Twentieth Century British History* 1, no.2 (1990).

[7] 'National visibility' and 'epidemic proportions' are practically inseparable in this context. See chapter three.

[8] Maclay, "British Mental Health Service," p.4; J.K. Wing, *Reasoning About Madness* (Oxford: O.U.P., 1978), p.199.

[9] Webster, "Psychiatry and the Early N.H.S.," p.104.

psychiatrist' allotted around twelve beds.'[10] This non-observation ward method of embedding psychiatric scrutiny in a general hospital setting has consequences for the visibility of 'attempted suicide': '[s]eventeen patients were admitted after attempts at suicide by various methods, the largest group being six cases of barbiturate poisoning'.[11] They are even more explicit about the changes in terms of visibility: '[v]ery many patients who would formerly have been treated only by physicians are now recognised as requiring psychological examination'.[12] However, this experiment is very small-scale.

By April 1950 in Manchester it is decided that to achieve progress in psychiatry, services should no longer be based around asylums, in direct conflict with recommendations from the local psychiatric specialists.[13] John Pickstone argues that this is driven by the idea that services based in remote mental hospitals with peripheral general hospital clinics 'will only serve to divorce the diagnosis and treatment of mental disorders still further from the broad stream of general medicine.'[14] Instead 'new psychiatry posts would be attached to district general hospitals'.[15] Thus in the early years of the NHS, integration is achieved by creating administrative structures that minimize the space between mental medicine and the general hospital. Of course, these crossover structures also reassert difference, which is further emphasised by Chief Medical Officer (1960-1973) George Godber's recollection that 'largely at the insistence of the Board of Control', all mental hospitals and mental deficiency hospitals had separate management committees. He claims that '[t]here was no reluctance locally to having mixed management groups – it was the Board of Control's influence.'[16]

A&E Under the NHS

Casualty departments are important under the NHS, as the reception (and sorting) centre for all emergencies, including those classed as 'attempted suicide'. However, Henry Guly notes that '[b]etween 1948 and 1960 there was little of substance in the medical literature describing casualty services.'[17] It is a particularly unfashionable area for doctors of the 1950s, which might seem strange after English and American makeovers in 1990s television drama serials *Casualty* and *E.R.* It has even been argued that it is not a specialism at all, because whilst 'almost every other specialty originates in increased subspecialisation, A&E has

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[10] J. Carson and E.H. Kitching, "Psychiatric Beds in a General Ward: A Year's Experience," *Lancet* 1, no.6559 (1949): p.833.

[11] Ibid.

[12] Ibid.

[13] Pickstone, "District General Hospitals," p.191.

[14] Manchester Regional Hospital Board Minutes (1950) quoted in Ibid.: p.192.

[15] Ibid.: p.191.

[16] Wilkinson, *Talking*, p.147.

[17] H.R. Guly, *A History of Accident and Emergency Medicine, 1948-2004* (Basingstoke: Palgrave Macmillan, 2005), p.4.

remained very general, covering the acute care of all emergencies.'[18] T.G. Lowden, a Consulting Surgeon working in Sunderland, writes a series of three articles in the Lancet entitled 'The Casualty Department' in 1956 (following his book of the same name published the year before). He opens the series comparing Casualty to a secretary's office, calling it a 'coordinating mechanism on the medical side' often performing administrative rather than strictly clinical work.[19] This coordinating role, brought about due to the comprehensive nature of the NHS, removes the kind of disputes seen in the previous chapter about the appropriate place to take 'attempted suicides', which are rooted in administrative divisions between psychic and somatic care and disputes about payment. For A&E to become a 'given' place to take an 'attempted suicide' requires the NHS.

In Lowden's *The Casualty Department* (1955), 'attempted suicide' is a distinct object of concern. He describes a coma patient sent in by her G.P., who regains consciousness on the way to hospital and shows 'no signs of illness' in casualty. She is discharged home with a future G.P. appointment. However, later that evening she takes a large overdose of the same drugs and the casualty officer is criticised (though not at an inquest) for not admitting the case. Whilst Lowden is sure that there is 'no reasonable basis for the criticism', this example shows that 'attempted suicide' achieves visibility (and causes anxiety) in casualty *because* it is read as a genuine attempt to end life that might be repeated more successfully at any time.[20] This concern is similar to the 'renewal' concerns in the police watching disputes.

Lowden argues that because of coroners' almost invariable reference to 'mental instability' in cases of suicide, '[a]ttempted suicide should therefore logically be an indication for psychiatric treatment… and *all such cases should be treated at a mental hospital*, unless the medical or surgical condition is so great that general hospital admission is necessary.'[21] The mental hospital is the most appropriate place for an 'attempted suicide', so long as 'medical or surgical' treatment is unnecessary, a position that evinces a clear psychological / general medical differentiation. He acknowledges that mental hospital admission is not often effected, so 'cases of attempted suicide who do not require admission for their organic lesions often call for a decision on disposal.'[22] Again, 'attempted suicide' is an issue due to the *dual* concerns of 'organic lesions' and 'emotional states', the recurring poles of soma and psyche:

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[18] Ibid., p.xii.

[19] T.G. Lowden, "The Casualty Department. I. The Work and the Staff," *Lancet* 270, no.6929 (1956): p.955.

[20] ———, *The Casualty Department* (London: E. & S. Livingstone, 1955), p.254.

[21] Ibid. Emphasis added.

[22] Ibid.

'[m]uch depends upon the circumstances, and particularly the emotional state of the patient. Young girls who make a half-hearted attempt to commit suicide because they have misbehaved and missed a period may often be returned to the vigilance of their parents'.[23]

Some small, gendered part of the 'attempted suicide' stereotype emerges at a casualty department and such a case is characterised as falling between therapeutic regimes: unsuitable for mental hospital admission and unsuitable for admission on account of any 'organic' injuries, and so nothing much can be done, the patient should be sent home. The therapeutics are still too separate; different arrangements for psychiatric scrutiny are required in order to register a need for any kind of extended surveillance or investigation. Whilst the NHS is a key step in integrating therapeutic regimes, and A&E becomes the single site for all emergency admissions, a socially-directed 'attempted suicide' does not appear as a credible research object here. The scrutiny available at A&E is not sufficiently psychological or intensive to fabricate a credible 'social setting' around an 'attempted suicide', and this 'sorting' role seems to emphasise the *separation* of therapeutic regimes rather than bring them together. The visibility of the object also remains low, some way beneath 'epidemic' levels.

However, alongside A&E there is a continuing link between observation wards and 'attempted suicide' under the NHS. In 1949, the British Medical Association and Magistrates' Association's joint Report on Attempted Suicide and the Law (covered in more depth in chapter three) mentions observation wards as suitable places for 'suicidal' people:

'[i]n the event of a patient who is still suicidal refusing to remain in a general hospital and having no suitable place to go to, or refusing to go as a voluntary patient to a mental hospital and not being certifiably insane... the hospital would be justified in arranging with the relieving officer to send the patient for observation to an observation ward or to a mental hospital.'[24]

In the same year the abovementioned Withington Hospital (Manchester) experiment also shows how the observation ward is associated with 'suicidal attempts'. At the beginning of this general ward psychiatric scheme, the nurses 'were anxious to get every attempted suicide out of the hospital and into the observation ward.'[25] The success of their experiment undercuts the nurses' attitude that the observation ward is the only place for 'attempted suicide', but their reported first reaction exposes the traditional association. Ivor Batchelor argues in 1955 that in

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[23] Ibid.

[24] Psychiatry and the Law B.M.A. Committee, "The Law Relating to Attempted Suicide," *British Medical Journal* Supplement 2210, no.5406 (1947): p.103.

[25] Carson and Kitching, "Psychiatric Beds," p.833.

the case of attempted suicide '[w]here possible, immediate admission to the mental observation ward of a general hospital is the ideal arrangement.'[26] His observation ward studies are considered next.

Ward 3 of the Royal Infirmary of Edinburgh

Ivor R.C. Batchelor publishes eight articles on 'attempted suicide' between 1953 and 1955, based on clinical work at the 'Ward for Incidental Delirium', or simply 'Ward 3' at the Royal Infirmary of Edinburgh. He serves as a neuropsychiatrist in the Royal Air Force Volunteer Reserve during the Second World War, and joins the Royal Edinburgh Hospital under D.K. Henderson.[27] Henderson has been mentioned as co-author of an influential textbook,[28] but is much more significant than that. Professor of psychiatry at Edinburgh between 1932 and 1954, he is second only to Aubrey Lewis as an influential mentor to twentieth century British research psychiatrists. Sidney Crown recalls that Lewis used to refer to Henderson 'with a combination of sincerity and irony… as "The most distinguished psychiatrist in the United Kingdom".'[29] Batchelor remains at Edinburgh for nine years, leaving for Dundee in 1956, and takes part in a published discussion on the 'Legal Aspects of Suicidal Acts' in January 1958.[30] Erwin Stengel argues that Batchelor is 'the leading psychiatric authority' on 'attempted suicide' in Scotland.[31] He collaborates with Margaret B. Napier, senior PSW based at the Edinburgh Hospital for Nervous and Mental Disorders on three of the eight articles.

These studies emphasise the role of 'broken homes' and alcoholism in 'attempted suicide', two cornerstones of the socially-focused aetiology they construct. They are equivocal about the formal 'appeal character' of attempts, stating that 'it is doubtful whether it is an element in all suicidal attempts' and they worry that 'over-emphasis upon the "appeal character" of suicidal attempts might lead to an under-emphasis of their danger.'[32] Before these studies are analysed more closely, their national and institutional setting is described from two angles: the potential for crossover between psychological and general medicine, and the provision of high-intensity, environment-focused psychological scrutiny. These concerns, central to the analysis of observation wards in the previous chapter, remain vital here.

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[26] I.R.C. Batchelor, "Attempted Suicide," *British Medical Journal* 1, no.4913 (1955): p.595. See also R.A.J. Asher, "Arrangements for the Mentally Ill," *The Lancet* 268, no.6955 (1956): p.1266. N. Kessel and G. Grossman, "Suicide in Alcoholics," *British Medical Journal* 2, no.5268 (1961): p.1672.

[27] P.G. Aungle, "Sir Ivor Batchelor," *Psychiatric Bulletin* 29(2005).

[28] See introduction.

[29] Crown, "Personalities," p.264.

[30] D. Odlum et al., "Discussion on the Legal Aspects of Suicidal Acts," *Proceedings of the Royal Society of Medicine* 51, no.4 (1958).

[31] Stengel, "Attempted Suicide and the Law," p.118.

[32] I.R.C. Batchelor and M.B. Napier, "The Sequelae and Short-Term Prognosis of Attempted Suicide; the Results of a One-Year Follow-up of 200 Cases," *Journal of Neurology, Neurosurgery & Psychiatry* 17, no.4 (1954): pp.265-266.

'Suicide' and 'attempted suicide' are not crimes in Scotland, a situation described in more detail in chapter four which focuses upon a research unit at Ward 3. The lack of legal sanction in Scotland is regularly invoked in the late 1950s by those campaigning for decriminalisation south of the border (part of the growing post-war legal interest in suicide covered in chapter three). Decriminalisation unearths a 'standing arrangement' in Scotland of much relevance to 'attempted suicide.' In their research around a possible legal change, the Home Office enquires about Scottish hospital practices in 1958. These uncover 'a standing rule that patients who have attempted suicide are seen by a psychiatrist whilst still under treatment.' The history of this rule is not given. However, the general situation in Scotland is described as 'neither clear nor altogether re-assuring.'[33] After the law has been changed the Department of Health for Scotland again states (in January 1962) that '[t]here are at present standing arrangements at Scottish Hospitals for the psychiatric examination of patients who have attempted suicide and have been taken to hospital because of their injuries.'[34] Thus there are established arrangements in Scotland for focussing some form of psychiatric scrutiny (presumably from visiting consultant psychiatrists) upon patients presenting at general hospitals and read as having 'attempted suicide'. However, there appears to be only one Scottish site producing 'attempted suicide' studies during the 1950s.

An idiosyncratic, contested observation ward

During the early 1950s Ward 3 is under the administration of Senior Psychiatric Registrar J.K. Slater. Neil Kessel and Norman Kreitman both acknowledge the centrality of this ward to their respective work on 'self-poisoning' and 'parasuicide' in the 1960s and 1970s. The ward facilitates consistent psychological scrutiny upon patients presenting with a somatic injury. Kessel comments in 1965 that there are 'auspicious circumstances' for studying this particular subject in Edinburgh, because for 'many decades the Royal Infirmary has had an "incidental delirium" ward for patients who required overlapping general medical and psychiatric care.'[35] Kreitman recalls 'an excellent clinical service' and an 'ideal research base'.[36] The two parts of the transformation appear explicitly: overlapping therapeutic regimes and the possibility for high-intensity scrutiny (psychiatric research). The ward has some fame at Edinburgh's medical school, known among 'countless numbers' of graduates[37] and called a 'unique and traditionally

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[33] Letter from A.B. Hume to F.L.T. Graham-Harrison dated 16.06.1958, TNA: PRO: MH 137/383.

[34] Letter from P.A. Cox to J.D.J. Havard dated 16.01.1962, TNA: PRO: MH 137/384. There is at least one similar arrangement in England, in Sheffield from 1951. See chapter three.

[35] Kessel, "Self-Poisoning (1)," p.1265.

[36] D. Tait, "Norman Kreitman in Conversation with David Tait," *Psychiatric Bulletin* 19(1995): p.298.

[37] J.K. Slater 'Ward 3: A Revaluation for the Ward for Incidental Delirium' (October 1962) p.1, LHB 1/59/7 at Lothian Health Services Archive, University of Edinburgh. Graduates include G.M. Carstairs, head of Kessel and Kreitman's research unit. The memo is unattributed, but almost certainly written by J.K. Slater, the only person at the meeting for which the memo was produced with an explicit association

hallowed charge in the Royal Infirmary of Edinburgh.'[38] The ward features briefly in E.F. Catford's *The Royal Infirmary of Edinburgh*,[39] but the best history remains in an unpublished 1962 memorandum stored at the Lothian Health Board Archives in Edinburgh.[40]

In the first decade of the twentieth century, the ward provided 'a place of segregation for those patients – medical, surgical and otherwise – who, for various reasons… came to be difficult or noisy'.[41] This is a similar function to an observation ward. However, 'it was not long before the police realised that this charge provided a haven for many of their unruly customers, "delirium tremens" and such like'.[42] Then, supposedly as a 'natural step' after the First World War, an arrangement is made so that 'prisoners in the local jail and also Borstal boys would be admitted to this unit and have their surgical, medical or specialist treatment carried out.'[43] Crucially 'the authorities, never slow to recognise advantages, found that Ward 3 was admirably suited to their difficulties about failed suicides and thus followed other forms of poisoning, including the accidental ones.'[44] The ward's purpose significantly fluctuates over the century, but still fits into the pattern of associating 'attempted suicide' with observation wards.

The memo exhibits anxiety over the use of coercive measures, similar to Calder and Lewis' 1938 report on London observation ward practice (which concluded that 'cots with nets' should be classed as 'mechanical restraint' and excluded from the Maudsley). Whilst that report is commissioned due to concerns with nets over beds, the Edinburgh memorandum is anxious about locked doors: 'this ward alone in all our hospitals is under lock and key. The modern view resents this as an anachronism'.[45] This 'modern view' is part of the shift towards integration. However, too close an equation with observation wards is rejected by Slater, who argues that:

> '[n]o right thinking person would deny that a modern hospital must provide
> accommodation for psychiatric observation and in the absence of this the

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with Ward 3. It is prepared after a meeting about the Atkins Report (1962) on the Treatment of Acute Poisoning in Hospitals that recommends the establishment of Regional Poisoning Treatment Centres (RPTCs) around Britain Standing Medical Advisory Committee Central Health Services Council, "Report of the Sub Committee: Emergency Treatment in Hospital of Cases of Acute Poisoning," (London: HMSO, 1962).

[38] Slater 'Revaluation' p.4.

[39] E.F. Catford, *The Royal Infirmary of Edinburgh 1929-1979* (Edinburgh: Scottish Academic Press, 1984), pp.157-160.

[40] Slater 'Revaluation' p.1.

[41] Ibid.

[42] Ibid.

[43] Ibid.

[44] Ibid.

[45] Ibid. p.2.

psychiatrists have consistently cast covetous glances at Ward 3, but equally their claims have been defeated by the vote of the consulting staff who have recognised that, while a special opinion is likely to be sought, not infrequently, yet, in the first instance, every single admission to this charge was a medical or surgical problem and that the psychiatric opinion was needed if at all at a later stage'.[46]

A number of things require comment in this dense passage. Firstly, that 'Ward 3' has been the subject of 'covetous glances' by psychiatrists who want facilities for psychiatric observation. This implies that the ward must fulfil this function, at least in part. Slater resists these claims by psychiatrists by asserting the primacy of non-psychological therapeutics ('every single admission' is a 'medical or surgical problem'), whilst admitting that psychiatric input is valuable ('not infrequently'), in the appropriate place. He is anxious to stress that the current liaison / referral system works well: '[f]or many years a most happy arrangement along these lines has been in operation to mutual advantage.'[47]

Slater is most concerned to preserve the overall control that he believes would be ceded to psychiatrists, were 'Ward 3' to become simply an observation ward. This fear emerges implicitly, in his proposals to divide the ward 'into three easily identifiable categories' comprising a psychiatric and psychological observation unit, a poisons unit and a miscellaneous ward, including medical care of prisoners.[48] As part of what he calls 'carving up the long conception of Ward 3 appropriately' he proposes two linked wards: '(1) A psychiatric observation charge, the responsibility for which would be solely a matter for the Professor of Psychological Medicine; (2) A poisons unit, under the direction of a Physician on the staff who would work in close harmony with the Director of Anaesthetics, the Kidney Unit and others with the equipment necessary for the special case.'[49]

Even though observation wards in general are substantially mixed in their therapeutic capacities (mainly by *association* with general hospitals), the 'psychological' is seen by Slater as preeminent; their full title is, of course *mental* observation wards. The differentiation of therapeutic regimes is clear, as he 'concedes' full authority to the Professor of Psychological Medicine over the hived-off observation ward section, and brings in some very somatic therapeutics for the 'poisons' unit (which he sees as far more central to the identity of Ward 3) in 'anaesthetics' and a 'kidney unit'. He is anxious that 'self-poisoning' is not swallowed up by

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[46] Ibid. p.3.
[47] Ibid.
[48] Ibid. p.4.
[49] Ibid. p.3.

psychological medicine, and that the psychiatrists remain involved on a referral basis only. Indeed, he is explicit about the psyche-soma separation that he envisages, indicating that the observation unit and poisons unit are '*quite separate charges* although inter-related'.[50] To borrow a phrase from Ian Hacking, 'this is claim staking with a vengeance'.[51]

Stengel and Kessel engage in (specific Ward 3) counter-claim staking from the psychiatric side. Kessel claims in 1962 that the poisoning unit at Ward 3 'serves as a psychiatric sorting and disposal unit for cases of attempted suicide far more effectively than the traditional English observation ward, which dares cater only for those who have not rendered themselves unconscious or hurt as a result of their actions.'[52] Whilst Kessel cedes the 'poisoning unit' name, his focus is on psychiatric sorting and disposal, which is *complemented* by somatic therapeutics. Stengel claims in 1963 that 'in Edinburgh ['attempted suicides'] are admitted to an observation ward where emergency services for resuscitation are available – which is not the rule in psychiatric observation wards elsewhere.'[53] The ward is envisaged primarily as a (psychiatric) observation ward, with somatic therapeutics attached, rather than a poisoning unit with psychological scrutiny available on demand. The uneasy co-existence of psychiatric and somatic therapeutics is exceptionally well illustrated. Slater's proposed reforms do not happen, and this productive tension between therapeutic regimes continues, enabling the transformations involved in 'attempted suicide'.

In both Stengel and Kessel's accounts, the Ward's somatic therapies provide opportunities to scrutinise patients arriving at hospital with somatic injuries. Catford highlights the extensive role of social workers in this scrutiny, claiming that they 'play an important role and may find it necessary to keep in touch with patients of the [Poisoning Treatment] Centre and their families for a long period.'[54] The connections between social workers, families and post-War psychiatry are extensive and significant.

PSWs, child guidance and post-War political projects

As well as the institutional base of 'Ward 3', Batchelor and Napier's 'attempted suicide' is significantly influenced by and accessed through the practices of psychiatric social work. The roots of this profession lie in mental after-care and the child guidance movement. Vicky Long shows that in the late nineteenth and early twentieth century 'the Mental After Care

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[50] Ibid. p.4 Emphasis added.
[51] Hacking, *Taming*, p.65. Hacking is talking about the claims by Esquirol to cast 'suicide as a kind of madness'. Slater is making an institutional, rather than a disciplinary or professional claim, on cases of poisoning, on behalf of Ward 3.
[52] N. Kessel, "Attempted Suicide," *Medical World* 97(1962): p.314.
[53] E. Stengel, "Attempted Suicide: Its Management in the General Hospital," *Lancet* 1, no.7275 (1963): p.234.
[54] Catford, *Royal Infirmary*, p.159.

Association deployed lady volunteers to visit its charity cases in their homes or places of work to check on their progress and resolve any difficulties.'[55] Noël K. Hunnybun, Chair of an Advisory Committee of Social Workers and Senior PSW in the Children's Department at the Tavistock Institute, also mentions this Association in his genealogy of PSWs.[56] John Stewart shifts focus, arguing that PSWs emerge 'after 1918 in an organic relationship with child guidance'.[57] Hunnybun agrees, plotting psychiatric social work's development through 'the medium of child guidance'[58] and tracing the profession back through concerns expressed in Cyril Burt's *The Young Delinquent* (1925) which emphasises 'the importance of studying the child in relation to his family and social background.'[59] These concerns with 'families' and 'social background' are absolutely crucial, both to PSWs and 'attempted suicide'.

On an institutional level, the Tavistock Clinic's department for children opens in 1926; the Commonwealth Fund of America finances the London Child Guidance and Training Centre, established in Islington, North London in 1929.[60] Child guidance grows substantially during the inter-war period[61] and at the Tavistock under John Bowlby it is centrally concerned with 'maternal deprivation', an influential concept that locates psychopathology in mother-child attachments, and most influentially expressed in *Maternal Care and Mental Health* (1951).[62] Bowlby's work reconfigures the crux of parent-child psychopathology away from the intricate fantasies, envies and anxieties of orthodox psychoanalysis, focussing on 'real life events': '[w]here most psychoanalysts assume that neurotic symptoms originate from the patient's inner world of fantasy, Bowlby remained firmly convinced that traumatic events in real life were more significant—not only actual separation and loss, but also parental threats of abandonment and other cruelties'.[63] This constitutes a crucial emphasis on the social origin of psychopathology, and Bowlby's work relies significantly upon PSWs.[64]

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[55] V. Long, ""Often There Is a Good Deal to Be Done, but Socially Rather Than Medically": The Psychiatric Social Worker as Social Therapist, 1945–70," *Medical History* 55, no.2 (2011): p.225.

[56] N.K. Hunnybun, "Psychiatric Social Work," in *Social Case-Work in Great Britain*, ed. C. Morris (London: Faber and Faber, 1950), p.102.

[57] J. Stewart, ""I Thought You Would Want to Come and See His Home": Child Guidance and Psychiatric Social Work in Inter-War Britain," in *Health and the Modern Home*, ed. M. Jackson (London: Routldege, 2007), pp.111-112.

[58] Hunnybun, "Psychiatric Social Work," p.105. See also E. Heimler, *Mental Illness and Social Work* (Harmondsworth: Penguin, 1967), pp.44-45.

[59] Hunnybun, "Psychiatric Social Work," p.103.

[60] Ibid., p.104.

[61] Stewart, ""See His Home"."

[62] J. Bowlby, "Maternal Care and Mental Health," (Geneva: World Health Organization, 1951).

[63] A. Storr, "Bowlby, (Edward) John Mostyn (1907–1990)," in *Oxford Dictionary of National Biography* (Oxford: O.U.P., 2004).

[64] See E. Irvine, "Psychiatric Social Work," in *Social Work in Britain, 1950-1975: A Follow-up Study*, ed. E. Younghusband (London: Allen & Unwin, 1978), p.189.

As well as the establishment of the Tavistock's Child Guidance and Training Centre, 1929 sees the London School of Economics establish the first PSW training course for social science graduates. The Universities of Edinburgh (1944), Manchester (1946) and Liverpool (1954) follow suit.[65] Elizabeth Irvine[66] notes that PSWs can join the local authority mental health services after these are reorganised following the Mental Treatment Act 1930, and numbers rise from eight to twenty-six between 1951 and 1959.[67] This 1950s movement from mental hospital to local authority provides 'an opportunity to return to the focus on the patient in his family which had been eroded in many mental hospitals.'[68] Felix Post – who conducts studies around the same time as Stengel (early 1950s) and on the same London ward[69] – also becomes involved with the role of the family in mental illness, citing H.B. Richardson's *Patients Have Families* (1945) as a 'pioneer work'.[70]

The PSW training courses in Edinburgh are based in the Department of Social Studies, unlike those at Manchester and Liverpool, which are part of the Departments of Psychiatry.[71] Even so, it can be assumed that the Meyerian influence of D.K. Henderson over Psychological Medicine at Edinburgh makes it a conducive place for PSWs to work. This enables them to flourish, for whilst '[l]ip service was paid to Adolf Meyer's more global picture… only a minority of psychiatrists seemed to take this seriously in practice. These [who did] were *the best friends of the PSWs*, and valued their support in demonstrating the… tensions and conflicts in the family and social situation.'[72] PSWs are again intimately concerned with access to family and social conflicts in the aetiology and course of mental illness. Eileen Younghusband is perhaps the single most influential person in the field of social work in Britain in the twentieth century. In her two-volume retrospective of British Social Work published in 1978, she notes the 'complementary role' of social work in the treatment of mental disorder, stemming from wider acknowledgement during the 1950s of 'the profound influence which the family and social

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[65] Long, ""Good Deal to Be Done"," p.226. Hunnybun states that 'it was not until 1929 that psychiatric social workers were employed in this country.' Hunnybun, "Psychiatric Social Work," p.100.

[66] A PSW and prolific author on social work in Britain, who collaborates with Eileen Younghusband, among many other publications. Irvine, "Psychiatric Social Work."

[67] Ibid., p.179.

[68] Ibid.

[69] F. Post, "Mental Breakdown in Old Age," *British Medical Journal* 1, no.4704 (1951). See Stengel, "Enquiries into Attempted Suicide [Abridged]," p.617.

[70] F. Post and J. Wardle, "Family Neurosis and Family Psychosis," *British Journal of Psychiatry* 108(1962): p.147.

[71] Irvine, "Psychiatric Social Work," p.192.

[72] Ibid., p.178. Emphasis added. Irvine is talking specifically about 1950s mental hospitals.

environment had on the well-being and social functioning of mentally disordered people'.[73] Ideas about 'the family' and 'the social' are of great importance.

The concerns of (psychiatric) social work, centred upon the family and the child are part of much broader political project in post-War Britain.[74] The encounter of British psychiatry (especially workers at the Tavistock Institute) with the practicalities and casualties of the Second World War generates a huge number of interpersonally-focused psychotherapeutic practices, such as Maxwell Jones' work on the therapeutic community,[75] the 'Northfield experiments' of Wilfred Bion, John Rickman, S.H. Foulkes, Tom Main and others,[76] Adam Curle and Eric Trist's notion of 'transitional communities' in resettling prisoners of war,[77] and John Rawlings Rees' work on army selection procedures.[78] Influential studies from Aubrey Lewis' Social Psychiatry Research Unit by George Brown, Morris Carstairs, John Wing and others build upon this work, focussing upon the role of the family in the course and recovery rate of conditions such as schizophrenia.[79]

Nikolas Rose describes this post-War project in terms of 'minimizing social troubles and maximizing social efficiency'[80] and notes that psychiatric social case work, through ideas about familial relations, is able to access and intervene upon 'the internal world of the home... in a new way'.[81] Mathew Thomson argues that social workers are seen during the 1950s and 1960s as 'shock troops' of a movement to spread psychological and psychiatric understandings of self and surroundings, with 'an ability to reach into the home'.[82] Eghigian, Killen and Leuenberger describe a post-War 'new wave of state interventionism... directed at women, children, and

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[73] E. Younghusband, *Social Work in Britain, 1950-1975 : A Follow-up Study* (London: Allen and Unwin, 1978), p.165.

[74] For an interesting account of the turn to the 'social' in the USA, see M.E. Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980* (London: University of Chicago Press, 2011).

[75] Jones, a pioneer of the 'therapeutic community' states that '[t]he war years were my salvation', as his work at Mill Hill on 'effort syndrome' provided the basis for his first therapeutic community. M. Jones, *Social Psychiatry in Practice: The Idea of the Therapeutic Community* (Harmondsworth: Penguin 1968), pp.16-17.

[76] Harrison and Clark argue that '[t]he experiments were an important landmark in the evolution of theory and practice in group psychotherapy and in the therapeutic community movement.' T. Harrison and D. Clarke, "The Northfield Experiments," *The British Journal of Psychiatry* 160, no.5 (1992): p.698. See also T. Harrison, *Bion, Rickman, Foulkes, and the Northfield Experiments: Advancing on a Different Front* (London: Jessica Kingsley, 2000).

[77] A. Curle and E.L. Trist, "Transitional Communities and Social Reconnection," *Human Relations* 1, no.2 (1947).

[78] J.R. Rees, *The Shaping of Psychiatry by War*, vol. 3078 (WW Norton, 1945).

[79] G.W. Brown et al., "Influence of Family Life on the Course of Schizophrenic Illness," *British Journal of Preventive & Social Medicine* 16, no.2 (1962).

[80] N. Rose, *Governing the Soul : The Shaping of the Private Self* (London: Free Association Press, 1999), p.171.

[81] Ibid., p.175.

[82] M. Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: O.U.P., 2006), p.269. Thomson is describing the *aspirations* for a new, enlightened, psychologised sense of selfhood.

families.'[83] The goal of all this prescription, intervention, counselling, casework, psychological analysis and measurement is to produce what Rose has called the 'responsible autonomous family'[84] a nuclear, private, productive unit comprising well-adjusted, physically and psychologically healthy citizens.[85]

Governmental concern with increasing the number of social workers to this end is noted by Younghusband in 1951, who points out that the Cope and the Mackintosh Committees are at that point considering 'the supply and demand, recruitment and training of almoners, and of psychiatric social workers and other social workers in the mental health service.'[86] She is famously associated with the Younghusband Report (1959),[87] which leads to the establishment of the National Institute for Social Work Training (1961) and the Council for Training in Social Work (1962).[88] Explicitly political intervention is also noted by Richard Titmuss in his lecture to the 1961 NAMH Annual Conference. He notes that '[n]umerous Royal Commissions and committees of enquiry have discovered in recent years the virtues of the normal social environment – or as near "normal" as possible'.[89] This is key in the wider project of constituting Rose's 'responsible autonomous family', where this family is 'bound into the language and evaluations of expertise at the very moment they are assured of their freedom and autonomy.'[90]

PSWs are an obvious expression of this psychologised turn towards 'the social' as well as being key instruments in the development and increasing ubiquity of such perspectives. In 1951 Aubrey Lewis claims in his Morrison Lectures (delivered in Edinburgh) on 'Social Aspects of Psychiatry' that 'until comparatively recently explicit concern about these matters was rare… Times have changed. The psychiatric social worker is an essential member of the mental hospital or clinic staff.'[91] The potential compatibility or even mutually reinforcing character of PSW scrutiny and 'attempted suicide' emerges in Younghusband's discussion of the rise of

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[83] G. Eghigian, A. Killen, and C. Leuenberger, "The Self as Project: Politics and the Human Sciences in the Twentieth Century," *Osiris* 22, no.1 (2007): p.22.

[84] Rose, *Governing the Soul*, pp.155-181, 205-213.

[85] See also J. Welshman, "In Search of the 'Problem Family': Public Health and Social Work in England and Wales 1940–70," *Social History of Medicine* 9, no.3 (1996).

[86] E.L. Younghusband, *Social Work in Britain: A Supplementary Report on the Employment and Training of Social Workers* (Dunfermline: Carnegie United Kingdom Trust, 1951), p.81. For more on social work committees and the failure to implement their findings, see R.M. Titmuss, "Community Care: Fact or Fiction?," in *Commitment to Welfare*, ed. R.M. Titmuss (London: Goerge Allen and Unwin, [1961] 1968).

[87] Ministry of Health, "Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services (Younghusband Report)," (London: HMSO, 1959).

[88] L. Faithfull, "Younghusband, Dame Eileen Louise (1902–1981)," in *Oxford Dictionary of National Biography* (Oxford: O.U.P., 2004).

[89] Titmuss, "Community Care," p.105.

[90] Rose, *Governing the Soul*, p.208.

[91] Lewis, "Social Aspects," p.215.

PSWs as conflicting with pre-1959 arrangements for mental healthcare outside of hospitals. She argues that under the old Lunacy and Mental Treatment Acts, after-care is the province of Duly Authorised Officers (DAOs), whose traditional role concerns psychiatric emergencies (deemed unfit or unsafe to remain 'at large') with frequent use of compulsion.[92] This is said to feed into a simplistic attitude to mental disorder, perpetuating the assumption 'that people were either sane, to be left alone, or insane and "subject to be dealt with"'. Younghusband considers this 'quite inadequate' for the new breed of social work which calls for 'a social frame of reference, a fuller recognition of the complexity of human motivation and behaviour, and particularly of family and social interaction.'[93] It is startling just how far Younghusband's general description of developments during the 1950s maps onto the object of 'attempted suicide' being tracked here, especially the complex motivation, and 'social frame of reference'.[94]

Observation wards, PSWs and the production of the 'social setting'

The potential for psychiatric *and* general medical therapeutic approaches at observation wards (as well as a casual association with 'attempted suicide'), meshes with a broad turn to psychosocial explanations and interventions during the early post-War years in Britain. However, it is not simply that the mixed scrutiny of observation wards is complemented by the psychosocial turn, but that increasingly, PSWs are attached to such wards. Pentreath and Dax's 1937 survey notes that '[t]he social worker investigated the history of many of these cases, often interviewing friends or relatives in their own homes, so that a better idea of the domestic conditions could be obtained'.[95] They also claim that observation wards 'have the closest contact with the relatives'.[96] This is a space where a vision of the family or domesticity is likely to be brought to relevance and prominence.[97] In 1940 the observation ward's fourteen-day period of detention is described as an opportunity to have the patient's history and background investigated by 'that essential member of the unit, the psychiatric social worker.'[98] Hunnybun includes the observation ward as a potential setting for PSWs working with adults,[99] adding with some satisfaction that PSWs are gaining in prestige and wider recognition. When it comes to 'helping people to understand and meet their emotional

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[92] Younghusband, *Social Work in Britain*, p.164.

[93] Ibid., p.165.

[94] DAOs are replaced by Mental Welfare Officers (MWOs) in 1959.

[95] Pentreath and Dax, "Observation Wards," p.354.

[96] Ibid.: p.364.

[97] Despite Hopkins positing 'domestic stress' as a precipitating factor for 'attempted suicide' and publishing his observation ward study in the same year, he does not mention a social worker (psychiatric or otherwise). However, he has an interest in child guidance, a profession central to the development of psychiatric social work.

[98] E.N Butler 'Observation Units' p.726.

[99] Hunnybun, "Psychiatric Social Work," p.117.

problems' PSWs are increasingly called upon to make 'a valuable contribution' in settings other than their traditional fields of child guidance clinics and mental hospitals.[100]

The PSW contributions in Batchelor and Napier's 'attempted suicide' studies are described as carrying out 'follow-up'[101] collecting 'social data'[102] and 'obtaining data from the families'[103] which can now be viewed in turn. The arrangements denoted by 'follow-up' comprise:

> 'personal re-examination of the patient, or by interviewing the nearest relative or other responsible and informed person. In six cases a psychiatric social worker in another part of the country made a home visit for us; in two cases we got a written report from the individual's general practitioner; and in two further cases a written account from another reliable informant.'[104]

It is unclear how much of this follow-up involves home visiting, but it is safe to assume a significant proportion is carried through such visits. John Stewart emphasises 'the centrality of the home to child guidance and the part therein of the psychiatric social worker'[105] during the interwar period, and that 'through the medium of the psychiatric social worker' child guidance becomes less focused upon the child as an individual, with more emphasis upon 'the child in its domestic setting'.[106] Practically, this is underwritten not simply by a chain of associations linking psychiatric social work to domesticity through the concerns of child guidance, but by the fact that it is PSWs who 'carry out home visits when these are considered desirable.'[107] Indeed, sometimes '[s]ocial workers sought to visit the home even before a clinic visit.'[108] Bridget Yapp, co-author of *An introduction to child guidance* (1945) with Mary Burbery and Edna Balint, claims that the '"child's difficulties cannot be understood without the fullest possible knowledge of the circumstances of his life, including the sort of home in which he lives."'[109] PSW Moya Woodside uses extensive home visiting when collaborating with psychiatrist Eliot Slater on *Patterns of Marriage* (1951) which investigates 'assortive mating'

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[100] Ibid., p.124.

[101] Batchelor and Napier, "Sequelae," p.261.

[102] I.R.C Batchelor and M.B. Napier, "Attempted Suicide in Old Age," *British Medical Journal* 2, no.4847 (1953): p.1187.

[103] I.R.C. Batchelor, "Alcoholism and Attempted Suicide," *Journal of Mental Science* 100, no.419 (1954): p.461.

[104] Batchelor and Napier, "Sequelae," p.261.

[105] Stewart, ""See His Home"," p.117.

[106] Ibid., p.115.

[107] Hunnybun, "Psychiatric Social Work," p.108.

[108] Stewart, ""See His Home"," p.118.

[109] Bridget Yapp, quoted in Ibid. In 1978, Irvine claims that this text is 'the only British book on the subject' and that it is 'unfortunate that no other books had appeared.' Irvine, "Psychiatric Social Work," p.183.

using hospitalised soldiers. Woodside is 'wholly responsible for the field-work. In nearly every case a visit was paid to the soldier's home.'[110]

At a very basic level, the second practice, collecting 'social data' or the 'social history' enables psychiatrists' reliable access to 'the social setting', and Stewart notes that '[p]sychiatrists appreciated such "social history".'[111] This is central to psychiatric social work, and can take up much of the PSW's time.[112] Underneath the broad umbrella of 'social history', Hunnybun focuses upon relationships first, and a generalised sense of background second, emphasising 'unsatisfactory parent-child relationships in the first months and years of life',[113] followed by a focus upon 'the family life and the social and cultural background of the patient'.[114] The influence of Bowlby is clear; this is unsurprising given Hunnybun is at the Tavistock.

Finally, when 'obtaining data from families', this kind of extended interaction with, and tabulation of relatives is seen as significantly new in the 1950s. Irvine mentions a 'traditional concern with families',[115] but also that '[t]his kind of work presented new technical problems. Social workers trained mainly for the individual interview… then had to deal, in conflicted family situations, with the anxieties and rivalries aroused in every member by an outsider's private contact with every other.'[116] Thus PSWs utilise new techniques when rendering the patient's 'social constellation', home, or domestic background.

Batchelor and Napier: therapeutic crossover, intensive scrutiny and John Bowlby

In Batchelor and Napier's studies, the combination of observation ward scrutiny and PSW practice is *made meaningful* through the conceptual apparatus of John Bowlby, which roots adult mental disorder in real-life (as opposed to symbolic/fantasy) traumatic experiences of loss and separation in infancy. Thus the opportunities for psychiatric scrutiny of physically injured patients, and access to a social, interpersonal, domestic background, are guided by the concept that childhood emotional deprivations feed into present psychopathology. After introducing the samples and recapitulating the important details about 'Ward 3', the

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[110] E.T.O. Slater and M. Woodside, *Patterns of Marriage: A Study of Marriage Relationships in the Urban Working Classes* (London: Cassell, 1951), p.14. See chapter three for analysis of Woodside's small study of 'attempted suicide at Guy's in 1958; see chapter four for more on the influence of marriage guidance and PSWs in 'attempted suicide' studies.

[111] Stewart, ""See His Home"," p.118.

[112] Hunnybun considers home visiting and social histories together as he notes 'the appointment… of social workers for home visiting and the taking of social histories.' Hunnybun, "Psychiatric Social Work," pp.102, 107, 118. Irvine, "Psychiatric Social Work," p.178.

[113] Hunnybun, "Psychiatric Social Work," p.101.

[114] Ibid.

[115] Irvine is specifically talking about a 1954 survey suggesting more generally that 'as PSWs became better accepted in the [mental] hospital, they were increasingly being assimilated into a patient-centred culture and drawn away from their traditional concern with families.' Irvine, "Psychiatric Social Work," p.178.

[116] Ibid., p.178.

intellectual and practical labour of Batchelor and Napier is analysed in their construction of a present 'social constellation', and pathogenic childhood 'broken home'. These are deployed to explain 'attempted suicide' as a pathological reaction. The intent or purpose of the 'attempt' is particularly complicated because the principal aetiological factor (the 'broken home'[117]) is in the distant past compared to the 'attempt'. An emphasis on social history over social precipitants is evident, but there is significant awareness of the social repercussions of 'attempted suicide.'

The key sample behind all the studies is two hundred consecutive cases of attempted suicide admitted or transferred to 'Ward 3' of the Royal Infirmary of Edinburgh between 1950 and 1952.[118] This sample provides many sub-populations for analysis, such as the elderly,[119] the psychopathic,[120] the alcoholic,[121] and those known to have 'attempted suicide' more than once.[122] Of most interest here are the two studies that use the entire sample. 'Broken Homes and Attempted Suicide' (1953)[123] and 'The Sequelae and Short-Term Prognosis of Attempted Suicide' (1954)[124] constitute an initial analysis and one-year follow-up respectively.[125]

The opportunities for mixed therapeutic scrutiny provided by Ward 3 come to light when defending the policy of discharging patients home (sometimes with a commitment to return as an outpatient). They emphasise that every patient is 'thoroughly assessed from the psychiatric, physical, and social aspects' before discharge, and thus any decision is taken 'on the basis of considerable knowledge.'[126] This is favourably compared to other places, with a sense that Ward 3 is exceptional: '[i]t might well be unjustifiable to dispose similarly of a group of attempted suicides who had been more superficially examined.'[127] The necessity of all three assessment areas, 'psychiatric', 'physical' and 'social' is repeated in 'Management and Prognosis of Suicidal Attempts in Old Age': 'the physician, psychiatrist and psychiatric social

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[117] This is knitted into a concern about alcoholism, as might be expected on an 'incidental delirium' ward.

[118] Batchelor and Napier, "Broken Homes," p.101. It is notable, given the above discussion of idiosyncrasies, that Batchelor and Napier call Ward 3 an 'observation ward' without qualification. See for example Batchelor and Napier, "Sequelae."

[119] Batchelor and Napier, "Old Age," p.1186.

[120] I.R.C. Batchelor, "Psychopathic States and Attempted Suicide," *British Medical Journal* 1, no.4875 (1954): p.1343.

[121] Batchelor, "Alcoholism," p.453.

[122] I.R.C. Batchelor, "Repeated Suicidal Attempts," *British Journal of Medical Psychology* 27, no.3 (1954).

[123] Batchelor and Napier, "Old Age."; ———, "Broken Homes."

[124] Batchelor and Napier, "Sequelae."

[125] I.R.C. Batchelor, "Management and Prognosis of Suicidal Attempts in Old Age," *Geriatrics* 10, no.6 (1955). The only article not to use this sample explicitly is Batchelor, "Attempted Suicide.", written for the *British Medical Journal*'s 'Emergencies in General Practice' series, and is more general.

[126] Batchelor and Napier, "Sequelae," p.265.

[127] Ibid.

worker should collaborate'.[128] This shows that as well as the mixed psyche-soma scrutiny, the 'social' is just as important. They emphasise 'how necessary it is in cases of nervous and mental illness to understand and to treat the patient in his social context'.[129] The crucial point here is that that Ward 3's provision of 'psychiatric' and 'social' scrutiny has the potential to *transform* the significance of a patient who arrives at hospital presenting with a 'physical' injury, which is read as a consequence of past emotional deprivation.

'Social constellations', 'broken homes' and Bowlby

PSW input is most obvious in 'Sequelae' (an article predominantly concerned with 'follow-up') where the 'Social Reverberations of Suicidal Attempts' are charted. It is claimed that:

> 'a small number, about 5% of the total group of 200, improved their social positions as a result of their suicidal attempts. If their acts were attempts to manipulate the environment in a direction favourable to themselves, they seemed to achieve that purpose…. A similar small proportion of the group worsened their positions.'[130]

This social context is focused upon the present, the social aftermath of 'attempted suicide'. The amount of effort required to chart these social reverberations (from clinical, hospital-based samples) is acknowledged. They argue that '[t]o record the social reverberations of a suicidal attempt is difficult, and to do so completely, probably impossible'.[131] They admit that only the most obvious or extreme consequences could be discovered, and that they 'know nothing of what had been for the meantime repressed successfully, but which may later have a traumatic influence.'[132] They were, however, 'impressed by how frequently the suicidal attempt had made no great commotion in the family group'.[133] This is 'the social', accessed through interviews with relatives and families, the core focus of PSWs. A presenting 'physical injury' is transformed into a psychosocial event through information provided (with some difficulty) by a PSW.

The notion of a present-centred 'appeal' – taken directly from Stengel's first publication on the subject from the previous year (discussed below) – is downplayed. Batchelor and Napier do acknowledge that many 'attempted suicides' bring attention to themselves through their actions, and gain treatment as a consequence. They flag up Stengel's interpretation 'that a

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[128] Batchelor, "Management and Prognosis of Suicidal Attempts in Old Age," p.292.
[129] Batchelor and Napier, "Sequelae," p.266.
[130] Ibid.: p.264.
[131] Ibid.
[132] Ibid.
[133] Ibid.

suicidal attempt constitutes an appeal to society for effective help.'[134] They understand such a present-centred appeal through a notion of 'temperament', claiming that this is most often the case for 'temperamentally unstable individuals chronically in conflict with their society.'[135] Whether this temperamental instability is due to developmental issues or innate qualities is left unsaid, but its significance is explicitly downplayed: '[i]t is doubtful if it is an element in all suicidal attempts'.[136]

'Social constellation' as 'broken home' through Bowlby

Batchelor and Napier subordinate present 'constellations' to 'broken homes', the most important part of this PSW-enabled social constellation. Throughout the articles it is repeatedly mentioned as a crucial factor.[137] The opening of 'Broken Homes and Attempted Suicide' (1953) draws explicitly upon Bowlby to claim that the 'social and medical importance of "broken homes" in affecting adversely the mental health of the children nurtured in them is now widely recognized.'[138] Whilst they note that Bowlby's *Maternal Care and Mental Health* stresses 'the supreme importance of mother love in infancy and early years',[139] they do not quote his assertion (in the same report) that 'the concept of the broken home is scientifically unsatisfactory and should be abandoned… In place of the concept of the broken home we need to put the concept of the disturbed parent-child relationship.'[140] Batchelor and Napier place significant emphasis on the idea that 'a broken home in the individual's childhood is aetiologically of considerable importance.'[141] Their objective is to improve upon these studies' small and selected samples, and their imprecision in defining a 'broken home'.[142]

They extend the concept of 'maternal deprivation':

> '[t]he traumatic effects of a lack of mother-love in childhood are nowadays everywhere recognized. Our findings also seem to emphasise the importance of a distortion or lack or absence of paternal influences in childhood. In a patriarchal society, the father is the figure in the home probably of chief importance… In investigations of the broken home situation there has been a tendency to lay

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[134] Ibid.: p.264.
[135] Ibid.: p.266.
[136] Ibid.
[137] Batchelor, "Management and Prognosis of Suicidal Attempts in Old Age," p.291; Batchelor and Napier, "Old Age," p.1190; Batchelor, "Psychopathic States," p.1343; ———, "Alcoholism," p.456.
[138] Batchelor and Napier, "Broken Homes," p.99.
[139] Ibid.
[140] Bowlby, "Maternal Care and Mental Health," p.12.
[141] Batchelor and Napier, "Broken Homes," p.100.
[142] Ibid.

almost exclusive emphasis on the role of the mother: the bias needs correcting.'[143]

Whilst this assessment broadens the *blame* for the seeds of psychopathology in early life, it is no less gendered in itself. The paternal role is linked to wider society, an example or template. The mother remains the provider of love. Batchelor and Napier's 'attempted suicide' is still a pathology produced through a model of 'home' that is explicitly normative: 'We have used the term "broken home" as it is commonly used, to imply that the children in that home have been deprived of a normal life with their parents.'[144]

Practically, childhood situations are positioned as most pivotal, and yet most difficult to access:

> '[t]o assess emotional climates with regard to their normality or abnormality, to
> express in simple objective or qualitative terms such things as parental quarrelling
> or rejection and cruelty in parental attitudes, to eliminate the bias of not only the
> patient but also of his observer… to give more than a very impressionistic opinion
> of a certain home in the retrospect of (usually) many years, is, of course, a most
> formidable task.'[145]

They admit that 'a certain amount of positive evidence has almost certainly been missed'[146] and that their tables of evidence cannot 'give a full statement of the complexity of the situations which were revealed'[147] even though 'in every case relatives were also questioned'.[148] The questioning of relatives by the PSW is explicitly intended to uncover the past social constellation. However, they admit that 'we have only the roughest clues as yet about how this factor ['broken homes'] operates'.[149]

This high intensity scrutiny, through PSW input, fabricates a credible 'broken home'. How far this formidable task of unearthing this past 'social constellation' relies upon PSW input is well-illustrated by an article produced without the formal collaboration of Napier. In 'Alcoholism and attempted suicide' (1954), Batchelor's key point is that '[t]here is no such entity as "The alcoholic suicide"'.[150] It is the narrowly clinical focus of the article that prompts this disavowal, as he admits that whilst presenting 'the clinical features of the cases, the wider social aspects

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[143] Ibid.: pp.105-106.
[144] Ibid.: p.101.
[145] Ibid.: p.104.
[146] Ibid.: p.103.
[147] Ibid.
[148] Ibid.: p.104.
[149] Batchelor, "Psychopathic States," p.1343. They add elsewhere that '[o]bviously also one cannot reach a satisfactory understanding of a particular suicidal attempt by means of still rather tentative views of the general significance of these acts.' Batchelor and Napier, "Sequelae," p.266.
[150] Batchelor, "Alcoholism," p.460.

have been largely neglected.'[151] There *are* links between alcoholism and 'attempted suicide', but the latter is constituted in such a way that links are not necessarily clinical: 'there is no uniform psychopathology. Many types of temperamental instability, neurotic conflict and psychotic reaction are encountered.'[152]

It is instead suggested that '[b]oth alcoholism and suicide have deeper, often apparently identical, bases in personality disorders and situations of severe maladjustment.'[153] In its strongest formulation, the 'broken home' predictably rears its head, as Batchelor falls back on the family environment constructed through Napier, thanking her at the end of the article for 'her assistance in obtaining data from the families of these patients'.[154] He is able to claim that 'alcoholism plays a significant role in the genesis of many suicidal acts. Alcoholism in first-degree relatives, particularly in the parents, has often disrupted the childhood home of those who later become suicidal'.[155] So 'alcoholism' and 'broken homes' are connected in the genesis of 'attempted suicide', although not in a simple clinical or psychopathological way. 'Attempted suicide' is thus cast as a social-psychological rather than simply clinical phenomenon.

As well as PSW connections between child guidance and broken homes, the absence of Napier shows how far the connection of childhood 'social maladjustment' to adult 'attempted suicide' depends upon access to families provided by PSWs. 'Broken home' concerns are a key part of a psychosocial constellation that is constructed around 'attempted suicide', and the collaboration between psychiatrist and psychiatric social worker models this rather neatly, providing authoritative access to a realm of 'social' information unavailable to Hopkins' observation ward in the late 1930s.

Rather than simply document how 'broken homes' are constructed and emphasised through PSW enquiry, it is possible to see how visions of 'the social' might be *organised* through these conceptual assumptions. This is most visible around statistics, as a considerable amount of effort is required to produce meaning when combining a set of numbers and the 'social constellation' made visible through PSW scrutiny. At first, it appears that numbers are the problem in themselves. Batchelor and Napier state that the statistical tables in these articles cannot give 'a full statement of the complexity of the situations which were revealed... no indication has been given of how some of these unfortunates were driven pathetically from pillar to post for their shelter.'[156] Thus, the statistics are not able adequately to show the social

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[151] Ibid.
[152] Ibid.: p.456.
[153] Ibid.: p.459. The association of Ward 3 with 'delirium tremens' has been noted in chapter two.
[154] Ibid.: pp.460-461.
[155] Ibid.: p.459.
[156] Batchelor and Napier, "Broken Homes," pp.103-104.

constellation. This is reiterated in 'Alcoholism and Attempted Suicide': '[t]hese bare figures give some measure of the great frequency, but can give no picture of the quality, of disturbances in the childhood home-life of individuals'.[157] Again, numbers can only express a limited amount of the 'social background'; numerical knowledge seems unsuitable for expressing childhood emotional deprivation.

Thus psychosocial 'attempted suicide' seems unsuited to statistical expression, but this also shows how Bowlby's ideas organise meaning out of complexity, despite the limitations of statistics. Whilst it is claimed that '[f]igures can, of course, indicate [things] only very crudely' they have meaning, nevertheless: [t]hey are, howevery [sic], *sufficiently striking*: parental alcoholism occurred in 38.1% of the cases, loss of the father in 33.3%, loss of the mother in 21.4%.'[158] The 'striking' quality is sufficient to trump any crudeness. In another example, the concession that, '[b]are, numerical data can give, of course, only a crude picture of family situations'[159] appears with the qualifier that 'these data are at least factual.'[160] Even more explicitly, in 'Broken Homes', commitment to complexity is significantly organised by overarching ideas:

> 'To discuss in isolation the importance of broken homes in the aetiology of suicidal attempts, is to incur all the risks attendant on focussing attention upon a single aspect of a highly complicated situation. On the other hand, the figures presented in the tables above are *so striking* in many respects that to abstract this aspect of the problem seems justifiable.'[161]

This idea is so powerful that it negates the absence of adequate control groups: '[d]espite the lack of fully reliable controls, it is clear from this investigation, and from the reported results of other workers, that the incidence of a history of a broken home is higher amongst suicidal individuals than it is in any other type of adult nervous or mental illness that has so far been investigated.'[162] A Bowlbian conception of a 'broken home' organises these numbers into meaning. Joan Scott argues that statistics are involved in 'organising perceptions of "experience"',[163] but here, Bowlby's conception of psychological development organises these statistics into significance: '[t]here seems, therefore, to be a particularly close relationship, which is *psychologically understandable*, between broken homes and suicidal trends.'[164] This is

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[157] Batchelor, "Alcoholism," p.453.
[158] ———, "Psychopathic States," p.1343. Emphasis added.
[159] Batchelor and Napier, "Broken Homes," p.104.
[160] Ibid.
[161] Ibid.: p.105. Emphasis added.
[162] Ibid.: p.107.
[163] Scott, *Politics of History*. See introduction.
[164] Batchelor and Napier, "Broken Homes," p.107-108. Emphasis added

explicit evidence of what might be 'foregrounded' under certain conceptual schemes, through what appears as 'psychologically understandable': a past social environment anchored around a psychopathological 'broken home'.

PSWs provide psychosocial information, which is structured and understood through ideas of psychopathological 'broken homes' that cannot be well-expressed in numerical form. The information is too complex, too rich, too varied, even too emotionally charged (children 'driven pathetically from pillar to post'), to be expressed by numbers. However, these numbers still have meaning, because the same ideas that make these childhoods relevant, organise the numbers so that they are 'psychologically understandable'.

It is not argued that Bowlby alone connects psychopathology to disruptions of nuclear, heteronormative family units (they also resonate with Meyerian 'life-events', for example). However, the connections between PSWs, child guidance, explicit reference to Bowlby and visions of childhood emotional environments show how important PSW input is to this 'attempted suicide' object. Given these links, it is unsurprising that an article co-produced by a PSW and with feedback from D.K. Henderson[165] attempts to follow in Bowlby's footsteps with studies of adults. However, these articles are also an important expression of, and constitute further evidence for, psychosocial explanations of human problems.

'Broken homes': aetiology and intent in the past

Whilst 'attempted suicide' clearly feeds into the broader psychosocial political projects in a general sense, there is a PSW-influenced aspect of Batchelor and Napier's work that is particularly relevant for studies of suicidal behaviour: the issue of intent. The detachment of intent from a simplistic 'wish to die' is absolutely crucial in the creation of an interpersonal, psychosocial disturbance from a presenting physical ('self-inflicted') injury.

The *historical* nature of the Bowlbian broken home complicates intent through notions of development. The significance of a 'broken home' for healthy development is clearly described in Batchelor's 'Repeated Suicidal Attempts' (1954). A 'low frustration threshold' is linked to the idea that certain individuals 'have never become properly socialised, have been deprived of, or have never responded to, those educational and moral influences which are essentially a training in the toleration of frustration.[166] Ideas of development help to undergird a socially-inflected 'attempted suicide' through the adverse impact of a 'broken home' in terms of 'adaptation'. He claims that '[w]e may suppose that a broken home tends to render the individual less adaptable and, therefore, more vulnerable to the stresses of adult life and in

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[165] 'We are grateful to Professor Sir David K. Henderson for his criticism and advice' Ibid.: p.99.
[166] 'The effects of broken homes in provoking these trends have been discussed elsewhere: Batchelor and Napier ['Broken Homes and Attempted Suicide'] 1953' Batchelor, "Repeated," p.161.

particular less able to deal satisfactorily with personal relationships.'[167] Thus any present, interpersonal social context is connected up to the psychopathological action because it is *mediated* by a lack of 'adaptability' caused by a 'broken home'.

In Bowlby's terms, these failures of adaptation are underpinned (at least in *Maternal Care and Mental Health*) by analogy with embryological development. He argues that 'pathological changes in the embryo's environment may cause faults of growth and development… This is a finding of great importance, which, as will be seen, is exactly paralleled in psychology'.[168] A second embryological analogy is deployed, linking the severity of developmental faults to the maturity of the tissue damaged; the earlier the damage, the more severe the consequences. For Bowlby, this constitutes a 'biological principle' which can connect 'far-reaching effects to certain emotional experiences occurring in the earliest phases of mental functioning'.[169] He is almost protesting too much when he rounds off the argument by saying that these ideas, 'so far from being inherently improbable, are strictly in accord with biological principle.'[170] Bowlby's encounter with ethological methods of sense-making and the languages of 'stress' and 'coping' (what Rose calls 'an heretical amalgam of psychoanalysis and ethology'[171]) proceeds throughout the 1950s. The ethological influences are only published in a coherent theoretical position in 1958.[172] It is not just the *changes* in Bowlby's account of this link between childhood experiences and adult 'attempted suicide' that complicate intent. *Any* such temporal link disrupts simplistic notions of intention, as these pivotal experiences are temporally distant or unconscious (or both).

What is important here is that 'the social' is rooted in the *childhood history* of the 'attempted suicide' and impacts upon the present through a disruption of the individual's ability to adapt and cope with present situations, which Bowlby describes as 'unseen psychic scars… which may be reactivated and give rise to neurosis in later life.'[173] The 'social constellation' most relevant to 'attempted suicide' does not lie in the environment that immediately precipitates the attempt, but in the deferred psychopathological effects of a childhood 'broken home'

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[167] They also argue that 'those rendered most vulnerable by their early experiences may tend to break down quickly' Batchelor and Napier, "Broken Homes," pp. 102, 106.

[168] Bowlby, "Maternal Care and Mental Health," pp.13-14.

[169] Ibid., p.14.

[170] Ibid.

[171] Rose, *Governing the Soul*, p.170.

[172] This is glossed in chapter four. See also Marga Vicedo who argues that 'Bowlby spent these years [1953-1958] building up his knowledge of imprinting and animal research, which he used to develop what he called the theory of component instinctual responses, later known as the ethological theory of attachment. In 1958 Bowlby published those views' M. Vicedo, "The Social Nature of the Mother's Tie to Her Child: John Bowlby's Theory of Attachment in Post-War America," *The British Journal for the History of Science* 44, no.3 (2011): p.420. See: J. Bowlby, "The Nature of the Child's Tie to His Mother," *International Journal of Psychoanalysis* 39, no.5 (1958).

[173] Bowlby, "Maternal Care and Mental Health," p.26.

which stunt the emotional development of the individual. It is the social as past impediment rather than present precipitant.

It gets even more complicated, because, like the division that Hopkins describes in his Liverpool studies between 'precipitating' and 'conditioning' causes, there is *negotiation* between past and present significance. In case studies of 'further suicidal attempts', immediate social precipitants are mentioned but in a complicated relationship to longer-term factors: an 'emotionally unstable, sexually promiscuous, and intellectually dull woman… impulsively attempted to drown herself after a tiff with a young man'; also, 'a single man… suffering from epilepsy with gross emotional instability, attempted suicide by barbiturate poisoning after minor thwarting.'[174] These are clearly contextualised with – given significant meaning through – longer-term factors, and detailed reconstruction of the precipitating situation is not attempted.

When studying the elderly, it is claimed that '[t]here is rarely any doubt that the suicidal attempt of an old person has been a genuine one'[175] but when discussing 'broken homes' the simplicity of this intent for other age groups is denied though general statements about 'a compulsive search for the love which they never had in any adequate measure as children' or '[q]uintessentially narcissistic and omnipotent attitudes which may find their final expression in a suicidal act' or '[i]dentification with, or the hope of rejoining a dead person.'[176] Intention is rendered more complicated because the meaning of the suicidal action is read through remote childhood events which are *not read as provoking individuals to end their lives*, but instead unable to adapt or to cope with frustration. Simplistic suicidal intent makes little sense in this reading, because 'maladjustment' does not map unproblematically onto either an 'appeal for help' or a straightforward 'wish to die'. Rather than saying that PSW scrutiny and a projection of a 'broken home' complicate intent, it might more precisely be said to make it less relevant.[177] However, it certainly makes the whole issue of 'suicidal behaviour' more complicated. Batchelor and Napier accept this, arguing that 'probably all suicidal acts [including] these attempted suicides were complexly determined'.[178] The past bleeds into the

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[174] Batchelor and Napier, "Sequelae," p.263.

[175] ———, "Old Age," p.1188.

[176] ———, "Broken Homes," pp.103-104, 107.

[177] Elsewhere, Batchelor emphasizes the 'considerable number of psychopathic and epileptic individuals amongst those who repeat their suicidal attempts.' He claims that 'there may be a close similarity in the suicidal attempt to the reaction of the frustrated child, who cries out in impotent rage "When I'm dead, you'll be sorry."' This is a sort of communicative attempt, but reduced to a symptom of 'psychopathic states.' Batchelor, "Repeated," pp.158, 162.

[178] He also writes that '[w]e are obviously confronted by complex problems.' ———, "Psychopathic States," pp.1345-1346.

present, complicating intent, which is crucial in the transformation of a physical injury to psychological disturbance.

Psychiatric social work brings an exceptionally high level of social and psychological scrutiny through interactions with families and relatives, making 'attempted suicide' meaningful through a past pathology and a present maladjustment. It is a highly complex psychosocial object, made credible because such involved scrutiny can be focused *routinely* upon people brought to hospital presenting with a physical injury. Psychosocial aetiology and intent are fabricated around a presenting physical injury by high-intensity, psychosocial scrutiny. The idiosyncratic arrangements at Ward 3 mean that the potential for this object to emerge at multiple sites, on an 'epidemic scale' is limited.

Stengel and Cook: PSWs and a present-centred appeal

The work of Erwin Stengel and Nancy Cook at London observation wards is acknowledged in the introduction as central to the phenomenon of 'attempted suicide as cry for help'. The extent to which Stengel and Cook's work is a product of wider developments in general hospital psychiatry is less well-known. Richard Mayou shows how Stengel and Cook's reading of 'attempted suicide' and the association of psychiatry with general hospitals are intimately connected:

> 'attempted suicide has accounted for a substantial proportion of the cases referred in descriptions of [psychiatric] consultation services published since 1960. However, until the 1950s, hospital cases of attempted suicide were rarely seen by psychiatrists, and indeed, the clinical characteristics were not defined until the publication of a monograph by Stengel & Cook (1958).'[179]

'Attempted suicide' and psychiatric expertise in general hospitals are inextricably linked, and this object is seen to emerge with Stengel and Cook. W.H. Trethowan's 1979 recollections bear out this transformation from attempted suicide being a matter of 'somatic sequelae' to 'psychological cry for help.' He does not recall a single lecture on suicide when a medical student at Cambridge University and then Guy's in the late thirties and forties,[180] but does remember that

> 'in the unsuccessful attempts – whether these ultimately proved fatal or not – it was the more immediate after effects which excited the greatest clinical interest – such as the cicatrisation [scarring or distortion of bodily tissue] which might follow corrosive poisoning, or dealing with the partial exsanguination [blood loss] and

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[179] Mayou, "General Hospital Psychiatry," p.774.
[180] Wilkinson, *Talking*, p.28.

various surgical complications in those who had made more-or-less determined attempts to stab themselves or cut their throats.'[181]

However, 'efforts to redefine unsuccessful suicide attempts in different terms', which owe much 'to the pioneer work of the late Professor Erwin Stengel in Britain in the early 1950s' result in the position that 'attempts at suicide have become such a well-established form of communication between a person in distress and his environment that a satisfactory substitute is almost impossible to find.'[182] These comments in the late 1970s show how far the idea of communication has become entrenched. The shift from 'somatic' to 'communicative' concerns is also exceptionally clear and linked to *Attempted Suicide* (1958). Therefore the intellectual and practical labour that undergirds this work, and the transformations between therapeutic contexts that enable and sustain it, are of central importance.

Stengel's work on 'attempted suicide' during the 1950s makes him an 'international authority in this field of psychiatry'.[183] Most of this work is written up into *Attempted Suicide* (1958) and principally based upon the investigation of general hospital patients referred to mental observation wards in London. He studies medicine in Vienna in the 1920s, flees the Nazis in the late 1930s and enters Britain with the help of Ernest Jones and the British Psychoanalytical Society.[184] According to one commentator, he is 'one of the most famous and successful of the psychiatric immigrants' from central Europe.[185] He becomes a research fellow at the Crichton Royal Hospital in Edinburgh in 1942, Director of Research at the Graylingwell Hospital in Chichester in 1947, and Reader in Psychiatry at the IoP in 1949, as well as a consultant at the Maudsley.[186] Michael Shepherd argues that Stengel is invited to the IoP because although Aubrey Lewis (in the Chair at this point) 'was always sceptical about the theory and practice of psychoanalysis he felt that it should be represented in an academic setting'.[187] In any case, according to Lewis' memorable phrase, Stengel is 'only singed by psychoanalysis'.[188]

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[181] Trethowan, "Suicide and Attempted Suicide," p.320.
[182] Ibid.
[183] U.H. Peters, "The Emigration of German Psychiatrists to Britain," in *150 Years of Psychiatry: The Aftermath*, ed. H.L. Freeman and G. E. Berrios (London: Athlone, 1996), p.569.
[184] P. Weindling, "Alien Psychiatrists: The Brisith Assimilation of Psychiatric Refugees," in *International Relations in Psychiatry: Britain, Germany, and the United States to World War II*
ed. V. Roelcke, P. Weindling, and L. Westwood (Rochester: University of Rochester Press, 2010), p.225.
[185] Peters, "The Emigration of German Psychiatrists to Britain," p.569.
[186] F.A. Jenner, "Stengel, Erwin (1902–1973)," in *Oxford Dictionary of National Biography* (Oxford: O.U.P., 2004).
[187] M. Shepherd, "The Impact of Germanic Refugees on Twentieth-Century British Psychiatry," *Social History of Medicine* 22, no.3 (2009): p.465.
[188] Jenner, "Stengel, Erwin (1902–1973)."

He publishes papers on 'Fugue States' (1941)[189] and 'Pathological Wandering' (1943)[190] whilst working in Bristol and Edinburgh respectively (acknowledging the input of D.K. Henderson in the latter). Early on in his time at the Maudsley, he publishes a paper on 'Suicide' (1950),[191] a literature review with no apparent clinical basis. He mentions his own work in the course of the chapter, noting that 'Stengel... in his studies of fugue states with the impulse to wander, expressed the opinion that these states were symbolic suicidal acts. The conscious fantasies of some of those patients demonstrated that meaning quite clearly.'[192] His interests and researches in Bristol and Edinburgh clearly approach complex issues of 'suicide' and 'intent'. He takes the Chair of Psychiatry at Sheffield in 1957, and serves as the last president of the Medico-Psychological Association.[193]

The cases that provide the basis for *Attempted Suicide* are split into five groups. Groups I and II are created using medical records from St Francis observation ward (1946-7) and the Maudsley (1949-50) respectively. These records are used to identify cases and to attempt 'follow-up' (the patients interviewed by Kreeger, in his role as psychiatric research assistant, the relatives by Cook, the PSW). Group III consists of patients interviewed by Stengel throughout 1953 at St Francis, soon after their 'attempt'. Group IV reverts to the study of records, this time from a north London observation ward (St. Pancras) for the same year (1953); these are compared with St. Francis. Group V is accessed through an arrangement with Dulwich General Hospital, where a psychiatrist 'in the team' is asked to assess every patient admitted there after a 'suicide attempt' between 1951 and 1953.[194] (There is also 'Group S' based on coroners' suicide statistics, which is kept separate and used as a basis for comparison and differentiation.[195])

St Francis' observation ward provides two of the five groups, and is the only site where psychiatric interviews are undertaken on the ward. After the 1929 Local Government Act, St. Francis is more closely associated with Dulwich General Hospital (where an 'attempted suicide' group is also analysed); from 1948 they are under the same Hospital Management Committee

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[189] Stengel, "On the Aetiology of the Fugue States."

[190] E Stengel, "Further Studies on Pathological Wandering (Fugues with the Impulse to Wander)," *Journal of Mental Science* 89(1943).

[191] Stengel, 'Suicide' in E. Stengel, "Suicide," in *Recent Progress in Psychiatry*, ed. G.W.T.H. Fleming, A. Walk, and P.K. McCowan (London: J. & A. Churchill Ltd., 1950), pp.691-703.

[192] Stengel, 'Suicide' in Ibid., pp.698-699.

[193] Shepherd, "The Impact of Germanic Refugees on Twentieth-Century British Psychiatry," p.465.

[194] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.38.

[195] This is an important group in one sense, as this material is deployed to reinforce the boundary between 'attempted suicide' and 'completed suicide'. However, the most important practices here are *not* comparative, but connected to the therapeutic potentials of observation wards.

(Camberwell).[196] Stengel's research project is funded by the Maudsley and Bethlem Board of Governors,[197] and there are many connections between St Francis and the Maudsley, enabling access to high intensity psychological scrutiny on a *general hospital ward*: Edward Mapother's then Aubrey Lewis' regular visits[198] (where Lewis meets Sainsbury); W.H. Trethowan 'learned a lot' as a locum there when at training the Maudsley[199]; Michael Shepherd recalls the 'old observation ward at St Francis Hospital with which I was associated for a long time'[200]; Felix Post conducts studies there.[201] Stengel and Cook refer to 'the Maudsley Hospital with which St. Francis' hospital is intimately associated.'[202] These arrangements and connections provide consistent psychological scrutiny from a world-leading centre of psychiatric research, to a ward of a general hospital.

For Stengel, Cook and Kreeger, '[t]he self injury in most attempted suicides, however genuine, is insufficient to bring about death and the attempts are made in a setting which makes the intervention of others possible, probable, or even inevitable.'[203] This 'setting' or 'social setting' is absolutely vital to the whole project. They argue for ambiguity in any 'intent to die', stating that '[w]e regard the *appeal character* of the suicidal attempt, which is usually unconscious, as one of its essential features'.[204] This is a significant shift from Batchelor and Napier. This is a present-centred appeal underpinned by unconscious intent rather than a frustration reaction linked to childhood maladjustment. Stengel separates 'attempted suicide' from 'successful' or 'completed' suicide, through characterising the 'attempt' as communication with the attempter's social circle. Thus great pains are taken to document this 'social constellation' of the attempt, arguing that 'if we think in terms of a social field we may say that those who attempt suicide show a tendency to remain within this field. In most attempted suicides we can discover an appeal to other human beings.'[205] This is based upon a complicated fusion of

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[196] 'St Francis' Hospital joined the King's College Teaching Group in 1966 and, following yet another reorganisation in 1974, became part of the Camberwell Health Authority. In 1984 it became the north wing of the Dulwich Hospital. It closed in 1991 and services moved to Dulwich Hospital or King's College Hospital.' Anonymous, 'Lost Hospitals of London' http://ezitis.myzen.co.uk/stfrancis.html accessed 21.08.2012.

[197] Stengel, "Enquiries into Attempted Suicide [Abridged]," p.620; Stengel, Cook, and Kreeger, *Attempted Suicide*, p.7.

[198] See chapter one.

[199] Wilkinson, *Talking*, p.30.

[200] Ibid., p.231. Presumably from July 1957 when 'the full-time services of an experienced psychiatric registrar from the Maudsley and Bethlem Royal Hospitals were made available.' 'Psychiatric Illness in the General Hospital' p.519 This is also presumably to what Mayou is referring when he claims that 'Professor Michael Shepherd supervised Maudsley senior registrars at Dulwich Hospital' Mayou, "General Hospital Psychiatry," p.774.

[201] Post, "Mental Breakdown in Old Age."

[202] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.95.

[203] Ibid., p.22.

[204] Ibid. Original emphasis.

[205] Ibid.

communication and unconscious motivation around intent specifically: '[n]o grading for seriousness [of intent] of large groups of suicidal acts can be really satisfactory, as unconscious motivation cannot be taken into account, quite apart from uncertainty about a patient's truthfulness.'[206] 'Attempted suicide' is rooted in the mixed therapeutics of observation wards, allied to PSW practice, which is used to construct a present-centred 'social constellation'. The intensity of psychological scrutiny across this study has a demonstrable relationship to the kind of object that emerges. In both Edinburgh and London, the different 'social constellations' derive from and require intense, PSW-enabled scrutiny.

From transformation to transfer: referral *between* therapeutic regimes

Whereas at 'Ward 3' most patients are admitted directly to the ward, a substantial proportion of 'attempted suicides' are referred from general hospitals to the London observation wards. In Group I (St. Francis records, 1946-1947), 10.3% of the total patients are admitted after a suicidal attempt,'[207] which amounts to 138 patients, 78 of whom (56.5%) are transferred from one of sixteen general hospitals in the area. Thus, over half of the patients in that group are 'collected' from sixteen different places and records of this 'attempt' – that would have otherwise remained disparate – are able to form the basis of a research object. The referral from hospitals to the observation ward is crucial. Group III (St Francis' patients interviewed by Stengel, 1953) comprises 167 patients which is 10.5% of all the admissions to the ward in that time.[208] 114 out of 167 (68%) are referred from 'other' hospitals (although it is unclear how many of these are from general hospitals, it is probable that the majority are, as in Group I).[209] In the final observation ward group, Group IV from St Pancras, 120 of 170 patients (70.6%) are transferred from other hospitals.[210] The majority of cases are transferred from general hospitals to the observation ward. Consistent movement from a place of general medical therapeutics to a separate space with potential psychiatric scrutiny underpins this research on 'attempted suicide'. It is important to note that Groups I and IV are scrutinised through records, but unfortunately there is no indication in the text how many of these cases are recorded as 'attempted suicide' on admission, and how many are retroactively diagnosed as such by the researchers in 1953. (Because two of the three observation ward groups are based on records, such practices must be kept in mind.)

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[206] Ibid., p.113.
[207] Ibid., p.43.
[208] Ibid., p.82.
[209] 'The proportions of the three modes of admissions were about the same as in group I.' Ibid., p.84.
[210] Ibid., p.105. The only comment Stengel has to make about this admission is that 'the proportions of men admitted through the police and that of women admitted through the Duly Authorized Officer being larger. The comparatively larger proportion of alcoholics among the men may have been responsible for the more frequent intervention of the police compared with Groups I and III.' ———, *Attempted Suicide*, p.94.

Just over two thirds of all of the observation ward 'attempted suicide' patients are admitted from other hospitals (67.2%). This dwarfs the other methods of registering (which are 'police' and duly authorised officer (DAO)). Commenting upon the difference between 'attempted suicide' and other observation ward cases, Stengel notes that the majority of 'attempted suicides' are referred from other hospitals, something which 'is certainly not so for all admissions to observation wards.'[211] So whilst Batchelor and Napier rely on transformations enabled by mixed therapeutics, Stengel and Cook rely on a different crossover: established, well-used channels of referral. The majority of 'attempted suicide' patients that form the basis of this study are referred from general hospitals to a place of secure, psychiatric scrutiny. The 'collating' function of referral is also important, because there exists no central collection agency recording 'attempted suicide'. Referral through observation wards and the resulting production of observation ward records forms the basis of this psychiatric concern. (It has already been shown that observation wards are associated with cases read as 'suicide attempts' due to their 'secure' status.) However, it should also be noted that almost a third of 'attempted suicides' are admitted to observation wards via the police and DAOs, so mixed therapeutics still obtains, if less prominently than at Ward 3.

Therapeutic mixing and rising psychiatric scrutiny in 1950s observation wards

In *Mental Illness in London* (1959) Vera Norris acknowledges that although the Board of Control is negative about observation units during the 1930s, this view is 'doubtless held because much of the observation unit accommodation was in public assistance hospitals which were unsuitable for this purpose'[212] and 'staffed by people with no psychiatric experience'.[213] Donal Early, surveying fifteen years' change in observation ward use in Bristol, notes that in 1947, the ward is 'without psychiatric cover, and in 1948 consultant psychiatric advice was available for the first time.'[214] It is not given that observation wards would have 'psychiatric advice' prior to the institution of the NHS in 1948, but becomes increasingly consistent from then on. In 1949, Gerald Garmany of the Westminster Hospital, London comments that his 'Regional [Hospital] Board is arranging for expert psychiatric care to be available in the observation wards'.[215]

Whilst observation wards facilitate general and mental medicine's interaction throughout this period, the level of scrutiny is judged to be low in most cases. In 1954 John Marshall writes that observation wards and psychiatric beds in general hospitals 'would encourage a closer co-

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[211] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.105.
[212] Norris, *Mental Illness*, p.91.
[213] Ibid.
[214] Early, "The Changing Use of the Observation Ward," p.262.
[215] D.R. MacCalman, G. Garmany, and R.F. Tredgold, "Discussion on the Development of Psychiatry within the National Health Service," *Proceedings of the Royal Society of Medicine* 42, no.5 (1949): p.366.

operation between psychiatry and general medicine so sadly lacking at present.'[216] However J.B.S. Lewis (Superintendent of St. Bernard's (Mental) Hospital, in Southall, Middlesex[217]) disagrees, arguing that these wards are 'the weakest link in the administrative set-up for the mentally sick'[218] *because* they 'form part of general hospitals' and not often run by clinicians with significant psychiatric expertise.[219] Spatial integration is seen as a hindrance rather than a help. Richard Asher disagrees in combative style the following year, arguing that 'a mental observation ward attached to a general hospital and administered by a general physician can do valuable work' because through them, '[t]he unfortunate compartmentation of medical from psychiatric work is lessened'.[220] Observation wards are clearly a contentious issue in the mid-1950s, but this should not obscure the slowly and unevenly increasing presence of psychiatric therapeutics. This process increases the potential to transform physical injury into an interpersonal disturbance, laying the foundations for an 'epidemic'. The more places in which this transformation is possible, the more possible it becomes for 'attempted suicide' to take on nationwide, epidemic proportions.

This increase should not be *over*stated, as even in the later 1950s (though before the passage of the Mental Health Act 1959), Norris observes that 'the primary function of these units is reception and diagnosis.'[221] In 1961, Eilenberg and Whatmore still argue that St. Francis' ward 'preserves its traditional role of diagnosis and disposal'.[222] However, progress seems even slower outside of the institutionalised channels that observation wards provide. In the late 1940s psychiatric access to general wards does become more consistent through referral. After leaving the Maudsley in the late 1940s, psychiatrist Max Hamilton joins University College Hospital (UCH) where '[a]t first, they didn't know what to do with me. After a while, I managed to establish a job in liaison psychiatry – having been called once to Casualty and once to the Obstetric Department, word got around that somebody was available.'[223] In 2003, Richard Mayou (founder of the Royal College of Psychiatrists' Section of Liaison Psychiatry) and Geoffrey Lloyd define liaison psychiatry as 'concerned with the management of general hospital patients with psychological problems.'[224] They lament that still, in the twenty-first

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[216] Marshall, "Mental Health Services," p.1484.

[217] He later works at the Bethlem Royal and serves on the Mackintosh Committee on 'Social Workers in the Mental Health Service'.

[218] The LCC's defence of the wards is contained in evidence submitted to the Percy Commission. J.B.S. Lewis, "Mental Health Services," *British Medical Journal* 2, no.4900 (1954): p.1354.

[219] Ibid.: pp.1354-1355.

[220] R.A.J. Asher, "Mental Health Services," *British Medical Journal* 1, no.4904 (1955): p.44.

[221] Norris, *Mental Illness*, p.234.

[222] M.D. Eilenberg and P.B. Whatmore, "Police Admissions to a Mental Observation Ward," *Medicine, science, and the law* 2(1961): p.96.

[223] Wilkinson, *Talking*, p.15. This story also appears in Mayou, "General Hospital Psychiatry," p.774.

[224] Lloyd and Mayou, "Liaison Psychiatry," p.5.

century, a 'fundamental obstacle' remains in the path of effective liaison, 'the separation between psychiatric and general medical care.'[225] However, the two twentieth-century success stories for liaison psychiatry – for psychiatric expertise at general hospitals – are recognition of 'postnatal depression' and 'patients presenting following episodes of deliberate self-harm' (DSH).[226] Whilst it remains the case that the contemporary psychological object of DSH is very different from 1950s 'attempted suicide', both objects are rooted in the transformation of physical injuries to psychological disturbances. New clinical objects are not only brought to prominence by psychological scrutiny in observation wards, but through other channels to psychological assessment within district general hospitals.

Attempted Suicide is not solely based upon observation wards either. The seventy-six patients in Group V are seen by a different arrangement at Dulwich General Hospital. This hospital is described in 1960 as without a psychiatric inpatient unit, where psychiatric scrutiny (up until 1957) is provided by a consultant psychiatrist not based there, whose principal function is to assess more severely disturbed patients. It is also possible to utilise 'a small research unit specialising in the psychological investigation of psychosomatic illness.'[227] (Given the intimate connection and spatial proximity between Dulwich and St Francis, it is probable that these consultant visits are from Aubrey Lewis.)

Between 1951 and 1953 a special arrangement is put into place to enable psychiatric scrutiny: '[i]t was arranged that during the period under survey every admission for attempted suicide should be seen by the psychiatrist in the team [Stengel].' 'It is possible that sometimes he was not consulted... This applies particularly to patients admitted to the surgical department.'[228] Not only do Stengel and colleagues have to 'arrange' to see all 'attempted suicide' patients, anxiety remains that patients might escape psychiatric scrutiny. Those admitted to the surgical department are presumed to be in the most danger of 'slipping through the net' (or avoiding the transformation), suggesting that once patients are admitted to other specialist departments it is more difficult to get them to see a psychiatrist; when one kind of 'specialist' attention is deemed to be required, it is difficult for another set of specialists to get access to patients. Thus 'separated therapeutics' influences the emergence of certain clinical objects – in this case, *against* 'attempted suicide' in the absence of special arrangements.

A similar process is noted during a discussion of a five-year study of psychiatric referrals at Guy's Hospitals in 1962. It is claimed that 'there is nothing new or unexpected in the

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[225] Ibid.
[226] Ibid.
[227] M. Shepherd, B. Davies, and R. Culpan, "Psychiatric Illness in the General Hospital," *Acta Psychologica et Neurologica Scandinavica* 35(1960): p.519.
[228] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.96.

observation that physicians call for psychiatric consultation more often than surgeons.'[229] This is attributed to physicians' greater interest in psychological factors and greater tolerance of 'mental symptoms' by surgeons. This shows that within a hospital – *between* the specialisms considered inside the label 'general medicine' – different regimes of referral and different professional identities complicate the constitution of any clinical object. This arrangement may have a role in blocking psychiatric attention to some of the more severely injured patients – those who require surgery rather than first aid, for example. Put another way, 'less gravely injured' patients have – in one sense at least – more chance of obtaining psychiatric attention when brought to a general hospital under this arrangement. Equally, they might be sent home from A&E if such arrangements are not in place.[230] The potential for more 'seriously' injured patients to escape Stengel's scrutiny has consequences for his ideas about demonstrative or appeal-based 'attempted suicide'. Referral is a vital practice that bridges therapeutic regimes, but not without complexities and constraints. The level of psychiatric scrutiny necessary to transform physical injury into interpersonal, emotional disturbance (even at therapeutically mixed and substantially secure observation wards) can be interrogated further.

Psychiatric Resources, Intensities of Scrutiny and PSWs

The transformations that underpin Stengel's production of 'attempted suicide as cry for help' are broached in the discussions of Hopkins' and Batchelor and Napier's studies. A central point to emerge from those discussions is that 'attempted suicide' needs significantly mixed therapeutics and much intellectual and practical work for the transformation from a physical injury to a psychosocial communication. What becomes clear on close reading is the possibility of relating differing intensities of psychiatric scrutiny to different kinds of clinical objects, and specifically different readings of intent.

Stengel and Cook's increasing fabrication of a present-centred 'social constellation' around the 'attempt' renders it *indivisible from* the 'intent'. This is because in order to have an intention to 'appeal', there must be some notion of an audience or outside observer. An appeal cannot be made without some idea of a recipient. This kind of 'appeal' contrasts with Batchelor and Napier's 'constellation' which renders intent and aetiology as complex in significant negotiations between past and present factors. A 'broken home' in the past impacts upon present abilities to tolerate frustration through an unstated notion of faulty development. A frustration reaction does not require the presence of recipients or observers. It remains

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[229] J.J. Fleminger and B.L. Mallett, "Psychiatric Referrals from Medical and Surgical Wards," *British Journal of Psychiatry* 108(1962): p.189.
[230] See Casualty section in this chapter, above.

'social', however, thanks to the notion of a 'broken home' as a past, pathological, social environment.

Observation wards' basic association with 'attempted suicide' – linked to legality and/or the desirability of 'safety' or 'restraint' – enables a distinct (if limited) object at one level of intensity. This is the view of 'attempted suicide' as 'bungled suicide' that Stengel explicitly sets up against. Perhaps the outer limits of diversity for this object, the furthest away it gets from merely incompetent suicide is shown by Trethowan, who recalls pre-Second World War that: 'although some minor attempts were even then regarded as hysterical – that is, relatively trivial',[231] they are not consistently seen as communicative. Additional practices including 'follow-up' and on-ward interviews (as opposed to simply the use of ward records) are required in order for Stengel and colleagues to make the observation ward material yield up the communicative articulation of 'attempted suicide'. There are three distinct sets of scrutinizing practices: observation ward records only, observation ward records and PSW follow-up, and interviews with a psychiatrist on the observation ward. Different arrangements of interrogative practices constitute different intensities of scrutiny, enabling different sets of objects. This does not imply a *continuous* scale of intensity; this would be fundamentally to misunderstand the nature of scrutiny, as somehow abstracted from practice(s).

Observation ward records alone constitute a low form of scrutiny. Group IV consists of St Pancras observation ward patients where '[t]he records of 1,408 (97.5%) patients were examined', yielding 174 'attempted suicides' from 1953. 'None of the patients of this group was interviewed by the authors.'[232] Early in the text it is claimed that the 'intent' behind the action will form a key part of the discussion of Groups III and IV.[233] However, this does not materialise for the St Pancras sample: '[d]angerousness and intent could not be assessed'[234] because 'the patients were not interviewed by a member of the team. For the same reason, the social constellation at the time of the act could not be established.'[235] (The chapter on St. Pancras does not fill three pages.) The issue of differentiating 'attempted suicide' from 'completed suicide' via 'intent' (rather than simply by 'survival') is not broached. The establishment of an 'appeal' function through charting the 'social constellation' is similarly untried.

Using observation ward records and Cook's PSW follow-up allows a little more of the 'social' to be fabricated around the attempt. In Group I they again sift through ward records.

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[231] Trethowan, "Suicide and Attempted Suicide," p.320.
[232] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.93.
[233] Intent would be 'carefully explored in Groups III and IV' Ibid., p.47.
[234] Ibid., p.94.
[235] Ibid.

Subsequently the patients, their relatives, friends, and even employers, are interviewed, subject to patient consent. The patients are mostly interviewed by Kreeger, and the relatives by Cook.[236] The association of PSWs with observation wards has been noted. For the London wards explicitly, Calder and Lewis' 1938 report states that '[e]ach observation ward has a full-time psychiatric social worker'.[237] The extent to which *Attempted Suicide* is based on PSW practice can be further glimpsed by the acknowledgement of 'unstinting help from the Psychiatric Social Workers in all the hospitals we worked in and from their office staffs, most of all from Miss. M. Seward, Senior Psychiatric Social Worker at St. Francis' Hospital Observation Ward.'[238]

The interview schedules for both Kreeger and Cook are reproduced in the text; they emphasise questions on matters presumably not found consistently in hospital records and case notes. For example, items on the psychiatrist's follow-up schedule for patients include: '[m]arked parental discord or other abnormal environmental stresses or relationships in childhood'.[239] Such questioning performs clear intellectual work, bringing patient history into a relationship with the 'suicidal attempt' and opening up similarities with Batchelor and Napier's work. However, the focus of the questioning is an exceptionally meticulous attempt to chart the present 'social environment' through 'repercussions', a clear indication of their importance, and what is needed to achieve its prominence:

> '[c]hanges in patient's human relationships and environment since attempt. The patient's views on the rôle of the attempt in bringing about changes in (a) social adjustment, (b) work and financial circumstances, (c) emotional adjustment, (d) sexual and marital adjustment – change in status, further children, etc., (e) change in mode of life of members of his family or friends.'[240]

The PSW's schedule (for relatives) contains clear 'emphasis on patient's relationships with other members.'[241] The very existence of a schedule explicitly for relatives is notable; it constitutes a research practice designed to produce an idea of 'interpersonal relationships' and to produce it, moreover, in explicit relation with an 'attempt at suicide'. As noted above, this interaction with relatives is enabled through the rise to prominence of psychiatric social work. Most of these informants are seen 'in their own homes, as visits were regarded as

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[236] Ibid., p.39.
[237] Lewis and Calder 'General Report' p.10
[238] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.39. Aubrey Lewis commends Seward's 'skill and thoroughness' in a twelve-year follow-up of 'hysterics' at the Maudsley A. Lewis, "The Survival of Hysteria," *Psychological medicine* 5, no.1 (1975): p.11.
[239] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.40.
[240] Ibid., p.41.
[241] Ibid.

essential for full information.'[242] Thus, the research object is produced from more intense scrutiny that the normal records can provide. This is acknowledged as vastly time consuming in 1952 (in the write-up of the preliminary study (Group I)), to the extent that Stengel is not surprised that the resources for this kind of study have not been previously available:

'[o]nly a small proportion of patients were in a mental hospital at the time of the follow-up. The rest had to be traced and their co-operation and that of their relatives had to be won. They proved a very elusive group and we came to understand why such a follow-up had never been carried out before in this country. I wish to pay tribute to my co-workers who overcame difficulties which often appeared insurmountable.'[243]

That these patients *have not been admitted to a mental hospital* is part of the reason they are considered so difficult to trace. As models of psychiatric provision move away from mental hospitals, the techniques used to produce social, biographical and follow-up information around mental illness must change. It is especially difficult to construct a psychosocial appeal around clinical records of people so inaccessible to psychological scrutiny. It becomes clearer why Frederick Hopkins cannot produce such an interpersonal object in the late 1930s. However, the practice of follow-up is also deemed deficient in a number of respects. The reason given for not attempting to ascertain 'motives' and 'suicidal intent' relation to Groups I and II is the passage of time between 'attempt' and interview. Whilst statements on these topics are collected, they are considered unreliable 'owing to inevitable distortions through lapse of time.'[244] Instead, the focus is upon the social constellation around the attempt over childhood circumstances.

The 'Results of the follow-up' section contains substantial examples illustrating '[t]he effects of the suicidal attempt on the patient's life situation'.[245] These include sub-sections such as 'Removal from the scene of conflict' and 'Changes in human relations and in modes of life.'[246] The first case study under the latter heading reads thus:

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[242] Ibid., p.39.

[243] Stengel, "Enquiries into Attempted Suicide [Abridged]," p.616.

[244] They also state that '*[m]otives*: no attempt will be made to discuss these… *Seriousness of the Attempt*: ...To discuss this aspect for Group I would not be profitable as it is hardly possible to establish the degrees of intent and self-damage so long after the attempt.'Stengel, Cook, and Kreeger, *Attempted Suicide*, pp.44, 47.

[245] Ibid., p.52.

[246] There are also categories less relevant for the new 'cry for help object' such as 'Suicidal attempt followed by permanent institutionalisation' and 'suicidal attempt followed by death soon' Ibid., pp.55-57.

'Mrs. F.I., born 1910, was unhappily married... They separated in 1944... Soon after she learnt of her impending divorce, her lover told her that he did not intend to leave his family… She became acutely depressed and tried to poison herself with aspirin…. Three months after the suicidal attempt she resumed work. Her lover left his family after all and at the time of the follow-up six years after her suicidal attempt they were living together and both declared that they were thoroughly happy. She thought that her suicidal attempt had "brought him to his senses". Her family, who had been against this relationship had become reconciled… The suicidal attempt here contributed to the solution of a conflict.'[247]

Thus, the 'attempted suicide' is given meaning not as a symptom of a depressive illness, childhood deprivation or other psychiatric abnormality. Through follow-up, it is given a social, communicative and instrumental meaning. A specific practical arrangement enables a presenting 'physical injury' to be redescribed as a communication.

The interviews that develop the observation ward records are flexible, opening up the question of how far research objects resemble the questions that help to produce them. More ambitious interview schedules are constructed at first, but they contain 'many items which it proved impossible to study systematically in the material available.'[248] So the interviews are a two-way productive process; the schedules affect the kinds of objects produced as the objects modify the schedules. It is clear that existing procedures for recording clinical objects in this observation ward are insufficient to support and (re)produce the psychiatric object of 'attempted suicide as cry for help'. Both institutional structures and facilities (through referral to an observation ward, between therapeutic regimes) *and* more specific research (PSW follow-up interview) practices are required.

The most intense scrutiny involves Stengel interviewing patients at St. Francis in 1953 (Group III). He again claims that '[a] number of aspects of attempted suicide cannot be satisfactorily studied months or years after the event. Some [of these aspects] have been investigated in this series, all of whom were interviewed... shortly after their admission.'[249] Thus the highest level of scrutiny achieved in this study involves a research psychiatrist interviewing patients soon after admission, with the investigation of the 'social element' in 'attempted suicide' as the purpose of the interview (allied with PSW follow-up). Observation wards and their records have their place, as does 'follow-up investigation', but for a truly satisfactory clinical object,

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[247] Of the nine cases under the heading, two attempts are by women, seven by men; the gendered nature of the 'cry for help' is still inconsistent. Ibid., p.58.

[248] They go on to say that 'in the schemata presented below only those items have been included about which it was possible to obtain information for the majority of patients.' Ibid., p.40.

[249] Ibid., p.82.

embedded within a social context, the on-ward interview is necessary. This is crucial when looking at the emergence of a certain reading of 'attempted suicide', one that privileges, and is constituted through such a social context. The potential for such a high level of psychiatric scrutiny is simply not available in the 'clearing house' of the pre-Second World War observation ward.

'Seriousness' and 'intent' are both vital to this object, and also (for Stengel) absolutely indivisible from the present 'social constellation'. The reconstruction of intent is the basis for the differentiation of 'attempted suicide' from 'bungled suicide' and a mechanism to downplay the significance of 'somatic' in favour of 'psychological' consequences. The discussion of this group focuses upon the 'seriousness of the attempt' which is differentiated four ways: absolutely dangerous, relatively dangerous, relatively harmless and absolutely harmless. This is a *somatic* scale. 'Degree of intent' is much more important, and is differentiated in three ways: serious, medium and slight.[250] It is not only 'assessed in the patient's statements to the psychiatrist' but also '[r]elevant utterances reported by the relatives were also taken into consideration, and so were the circumstances surrounding the attempt... In addition, the background of the suicidal attempt and its history were reviewed for evidence of the seriousness of the intent'[251] (although it is unclear precisely how these are collected, it is likely that the work was carried out by Senior PSW Margery Seward and staff at St. Francis). Psychological and somatic concerns are bifurcated into 'intent' and 'seriousness'. It is 'intent' that predominates when assessing the significance of the 'attempted suicide', and shows how far this category coincides with psychological scrutiny.

Case studies illustrate this, containing frequent references to a social environment that modifies assessments of (physical) 'seriousness'. For example, a woman who had taken a large dose of sleeping tablets and then 'called her sister with whom she was staying and told her what she had done... Her attempt was graded as *absolutely dangerous, with only slight intent*. Had her sister not been available the attempt would probably have proved fatal'.[252] A woman whose husband had been unfaithful 'took 100 tablets of codein-phenacetin compound when alone at home but knew that her son would come soon and she expected that he would find her alive... The attempt was graded as *relatively dangerous, with slight intent*.'[253] Even more explicitly, this discussion contains a section on the '[s]ite of attempted suicide' which details the 'patient's relationship to the social environment during the suicidal act'[254] which is further

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[250] Ibid., pp.84-85.
[251] Ibid., p.85.
[252] Ibid., p.86. Original Emphasis.
[253] Ibid. Original Emphasis.
[254] Ibid., p.90.

analysed through considerations of '"Special persons"... spouse, fiancée, lover, friend or colleague in a special relationship to the patient, while "others" are just members of the community, i.e. neighbours, passers-by, fellow-travellers, policemen.'[255] Mere case notes are insufficient for perhaps the most significant part of the psychiatric object, because the intent is based largely upon assessments of the surrounding environment and possible interventions, the very essence of the novelty of this kind of 'attempted suicide' object. The 'intent' and 'social constellation' are rendered indivisible – and indeed accessible at all – through the highly detailed case studies that Stengel's interviews provide, the result of intense psychiatric scrutiny. Whilst Stengel and Cook and Batchelor and Napier focus significantly different psychiatric scrutiny upon patients they would both agree that the significance of these physical injuries 'has to be deciphered and formulated.'[256]

Ann Cartwright argues that such 'structured interviews' as carried out by Stengel and colleagues (both on the ward and as follow-up) are advantageous because of 'the ease with which the data obtained in this way can be structured and analysed' but it also compels the investigator 'to determine the precise contents and limits of the study'.[257] The astute observation that 'the concept of morbidity [or pathology] in such inquiries "is most accurately defined not by the original ideas of what constitutes morbidity, but by the whole mechanism that is set up to measure it"'[258] focuses specifically upon practices. *Attempted Suicide*'s most quoted passage takes on a different hue:

> 'There is a *social* element in the pattern of most suicidal attempts. Once we look out for the element we find it without difficulty in most cases... If we think in terms of a social field we may say that those who attempt suicide show a tendency to remain within this field. In most attempted suicides we can discover an appeal to other human beings.'[259]

The idea of 'looking for' the social element, the intellectual move to 'think in terms of a social field' the 'discovery' of an appeal: all these are dependent upon specific research practices. The 'social field' is produced through them – finding relatives years after an event, sending letters asking for an interview, asking permission to speak to the former patient. It is quite a practical achievement to produce a credible social, interpersonal space around the 'paper

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[255] Ibid.

[256] Ibid., p.130.

[257] A. Cartwright, "Interview Surveys" (paper presented at the The burden on the community: the epidemiology of mental illness: a symposium, 1962), pp.34-35.

[258] Partially quoting U.S. Public Health Officer Theodore D. Woolsey, in Ibid., p.46.

[259] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.22. Original emphasis.

record' of an 'attempted suicide'. (This turn to 'the social' is further contextualised in chapter four.)

So, observation ward records are useful, follow-up is more useful still, but on-site interviews with the senior research psychiatrist are indispensable to a present-centred 'social constellation' in which to position the 'suicide attempt' in observation wards. It requires an exceptional amount of intellectual work, even in the rather favourable environment described. In this case, a present 'social context' is absolutely crucial to the idea of complex intent – the two are not meaningfully separate.

Concluding thoughts

Negotiations between psychological and general medical scrutiny continue in this period. Physical injury is transformed into psychosocial disturbance under the label 'attempted suicide' with greater regularity under the NHS, in processes that have more to do with the pre-NHS institution of the observation ward. These wards exist uneasily between separate therapeutic approaches, and the increased psychological scrutiny in them and in relation to general hospitals is of the highest importance for 'attempted suicide'. In this chapter it is shown that when crossover occurs – through mixed therapeutics, referral, or both – the scrutiny must be *intense*. Much of this intensity is provided by the follow-up practices and intellectual frameworks of psychiatric social work. Whether the 'social constellation' is fabricated around deprivations projected into childhood, or through a complicated 'appeal' to a present social circle, it is highly labour-intensive. This turn to the social, sketched in the introduction, and here mentioned as part of the rise of post-War social work, is further detailed in chapter four.

The following chapter describes how crossover between psychological and general medicine is given publicity and impetus by the Mental Health Act 1959 and the Suicide Act 1961. The 1959 Act represents a peak in efforts to integrate psychiatric and somatic therapeutics, to which the 1961 Act is connected, through concerns about psychiatric scrutiny at A&E departments. As this latter Act decriminalises 'attempted suicide', it alters formal NHS responsibilities for those considered to have performed that act. This impetus transforms 'attempted suicide' from something of an observation ward curiosity to a national epidemic. This has little to do with ideas of 'actual incidence' and more to do with the ways in which various institutional arrangements and practices produce, maintain and expand new fields of scrutiny populated with psychological objects or behavioural patterns.

Chapter 3: Ad Hoc Arrangements and New Impetus for Transformation (1959-1961)

At the end of Stengel's 1952 paper 'Enquiries into attempted suicide' he speculates about the potential scale of this phenomenon:

> 'if the appeal character is such an important feature of the suicidal attempt as we have made it out to be, is there not a likelihood that this powerful and dangerous appeal will be used more and more, especially in a society which has made every individual's welfare its collective responsibility? I think that this danger can easily be overestimated. "Attempted suicide" is a behaviour pattern which is *at the disposal of only a limited group of personalities*.'[1]

Raymond Jack argues that it is 'unreasonable to criticise Stengel on the basis of hindsight for his inability to predict the massive increase',[2] and Stengel is not alone in this lack of foresight. Kenneth Robinson, the most active Parliamentary agitator for suicide law reform (and Harold Wilson's Minister for Health 1964-68) neatly shows how the problem of 'attempted suicide' is a small one even in the late 1950s. In a speech to Parliament on October 31st 1958, he claims that 'I am not suggesting that this is a vast problem, but our attitude to it in some ways symbolises what we think about human frailty and about mental illness'.[3] However, rather than critique or excuse a lack of predictive power, this thesis asks a different kind of question entirely: how it is that 'attempted suicide' transforms from a behavioural pattern available only to a 'limited group of personalities' in the early-to-mid-1950s to what one clinician calls 'a major epidemic' by the mid-1960s?[4] The answer is to be found through continued analysis of how practices of referral and institutions with substantially mixed therapeutic capabilities become more and more common. This mixing of psychological and somatic medicine also needs opportunities for *intense* psychosocial scrutiny which enable this phenomenon to be produced on a wider scale, at new places, reliably, consistently and routinely.

The epidemic is fundamentally constituted by the practices through which it is recorded and administered. During the late 1950s (though before the legal changes of 1959), a number of ad

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[1] Stengel, "Enquiries into Attempted Suicide [Abridged]," p.620. Emphasis added.
[2] Jack, *Women and Attempted Suicide*, p.xii.
[3] Hansard HC Deb 31 October 1958, Vol 594, col 521.
[4] H. Matthew, "Poisoning in the Home by Medicaments," *British Medical Journal* 2, no.5517 (1966): p.788. The previous year, Kessel claims that '[d]eliberate self-poisoning is becoming more and more common and a matter of public health concern.' Kessel, "Self-Poisoning (2)," p.1340. By 1979 Trethowan states that 'as every casualty officer well knows, [this phenomenon has] now reached epidemic proportions' Trethowan, "Suicide and Attempted Suicide," p.320.

hoc practices focus small-scale psychiatric attention upon general hospital patients not in observation wards, enabling 'attempted suicide' to emerge. The legal changes contained in the Mental Health Act (1959) enable the further integration of mental and general medical therapeutics, removing all legal obstacles to the treatment of mental illness in general hospitals. Even the separateness of the observation ward is considered significantly undesirable by some after 1959. The Suicide Act (1961) decriminalises attempted suicide, which had only unevenly been considered a police matter even in the 1920s, and even more rarely after the inauguration of the NHS in 1948 (this is the sense in which the problem is 'not vast' for Robinson). The significance of the law change is that for the first time the government feels able to act in a prescriptive way, intervening in the management of 'attempted suicide' and actively promoting psychiatric attention, something much more difficult when the act is technically a common law misdemeanour.

Government intervention aims to make referral to a psychiatrist from A&E consistent on a nationwide scale. This multiplies the possibilities for an epidemic (although without providing any extra resources). 'Attempted suicide' thus becomes a coherent national concern, but the resources available are insufficient to fabricate a consistent 'social constellation' around the act. However, this basic coherence means that wherever appropriate resources are provided, the object can be found in abundance: an epidemic.

The Mental Health Act (1959) as the apogee of integration: psychiatry and the 'main stream of medicine'

Self-conscious efforts to achieve the equivalence of mental and physical medicine reach their zenith during this period, but have a broad history and continuing contemporary relevance. Minimizing the nosological and therapeutic importance of psyche/soma divisions is part of Wilhelm Griesinger's ideal in the mid-nineteenth century, Adolf Meyer's 'psychobiological' approach favoured by D.K. Henderson and R.D. Gillespie in the early-mid twentieth and continues to provoke debate in the twenty-first century over single speciality Mental Health Trusts.[5] These concerns are long-running, but still contextually specific. Integrative efforts in the 1950s and 60s based around psychiatric provision at general hospitals deserve special consideration; they are exceptionally self-conscious attempts at integration. The observation ward remains important in this process: many wards become treatment units in line with the prescient views of Pentreath and Dax[6] (as well as psychiatric liaison and referral services becoming more established). More broadly, the slowly changing functions of observation wards (seen in the previous chapter), play a key role in a rearticulation of 'attempted suicide'.

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[5] See 'Separated therapeutic approaches' section in the introduction.
[6] See chapter one.

Again, increased psychiatric provision enables the transformation of a 'physical injury' arriving at a hospital into an 'interpersonal disturbance' as a 'cry for help.'

Two narratives, the dominance of 'asylum-community' and economic concerns

Kenneth Robinson draws out two distinct threads, noting that although the Percy Commission Report and subsequent 1959 Act 'are complex... running through both are two simple concepts. First, that all distinction, legal, administrative and social, between mental and physical illness should as far as possible be eliminated; secondly, that patients who have no need of in-patient hospital care should, wherever possible and desirable, receive care and treatment while remaining in the community.'[7] In *The Politics of Mental Health Legislation* (1987), Clive Unsworth states also both, arguing that '[t]he Mental Health Act [draws] upon the logic of the view of insanity as analogous to physical disease and upon a reorientation from the Victorian institutionally-centred system to "Community Care".'[8] It is this second thread that dominates the historiography of mental health in the twentieth century – the move from 'asylum to community'. The Report and the 1959 Act are conventionally and broadly seen as marking a shift from 'institutional' or 'asylum' to 'community care' (termed 'deinstitutionalization' or 'decarceration').[9] This narrative also centrally acknowledges that 'the aspirations of the Percy Commission were never fully supported in legislation since… no additional money was made available.'[10] The mobilisation of political concerns around this idea of a 'gap' between the idealism of the report, and the financial provision for 'community care' is one reason why the binary of 'institution-community' remains durable.[11]

This binary fits uneasily with this account of 'attempted suicide' as it neglects general hospitals and observation wards, key sites for this epidemic. Rogers and Pilgrim retain the emphases of asylum and community even when discussing general hospitals. Although they acknowledge the efforts to integrate psychiatry and general medicine through District General Hospital (DGH) psychiatric units, which mean that psychiatry begins to operate under the same

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[7] K. Robinson, "The Public and Mental Health," in *Trends in the Mental Health Services*, ed. H.L. Freeman and W.A.J. Farndale (Oxford: Pergamon, 1963), p.16.

[8] Unsworth, *The Politics of Mental Health Legislation*, p.231.

[9] A.T. Scull, *Decarceration: Community Treatment and the Deviant: A Radical View* (London: Prentice-Hall, 1977). It should be noted that ideas of 'community care' are not restricted to mental health policy but have broader aims to 'reduce pressure on district general hospitals by providing alternative accommodation for the elderly, the mentally handicapped and the convalescent'. H. Glennerster, *British Social Policy since 1945*, 2nd ed. ed. (Oxford: Blackwell Publishers, 2000), p.163.

[10] H. Lester and J. Glasby, *Mental Health Policy and Practice* (Basingstoke: Palgrave Macmillan, 2006), p.27.

[11] Titmuss argues in 1961 that 'we are drifting into a situation in which, by shifting the emphasis from institution to community... we are transferring the care of the mentally ill from trained staff to untrained or ill-equipped staff or no staff at all.' Reprinted in R.M. Titmuss, "Community Care - Fact or Fiction?," in *Trends in the Mental Health Services*, ed. H.L. Freeman and W.A.J. Farndale (Oxford: Pergamon, 1963). also see Rollin H.R. Rollin, "Social and Legal Repercussions of the Mental Health Act, 1959," *British Medical Journal* 1, no.5333 (1963): p.788.

administrative frameworks as other medical specialisms, they claim that '[w]hat ensued was a transfer of asylum theory and practice to DGH units and no new evidence of staff involvement with the communities of the patients they admitted.'[12] Notions of 'asylum theory' and a neglected 'community' structure the analysis. Even more strikingly they characterize the Royal Commission on Lunacy and Mental Disorder of 1924-26, as containing an 'emphasis in 1926 on outpatients' clinics and observation beds in general hospitals (i.e. not in asylums)'. Their clarification of the significance of 'beds in general hospitals' – 'i.e. not in asylums' – is revealing of their focus, between asylum and community: general hospitals are significant because they are *not asylums* and are bundled in with outpatient clinics.[13] Instead of making the DGH part of an asylum-community narrative, the present approach draws from Nikolas Rose's argument that 'rather than seeking to explain a process of de-institutionalisation, we need to account for the proliferation of sites for the practice of psychiatry.'[14] Different sites mean different contexts that require and sustain different kinds of practice. Focus on the DGH is an important part of the answer to Eghigian's recent question: '*where* is psychiatry taking place?'[15] As the clinical object 'attempted suicide' emerges at the *interface* of psychiatric and general medical fields (as this boundary is reconstituted by the 1959 Act), much of the specific mental health policy discussion is not immediately relevant.[16] Although 'asylum-community' is important, it clearly does not exhaust and is not even particularly suitable for all analyses of change in this period.[17]

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[12] Rogers and Pilgrim, *Mental Health Policy in Britain*, p.65.

[13] Ibid., p.55. Recent examples of 'institution-community' binaries include M. Gorsky, "The British National Health Service 1948–2008: A Review of the Historiography," *Social History of Medicine* 21, no.3 (2008): p.449. and Lester and Glasby, *Mental Health Policy and Practice*, p.27.

[14] Rose, quoted in Rogers and Pilgrim, *Mental Health Policy in Britain*, p.73. Regardless, Rogers and Pilgrim base their account around the 'de-institutionalisation poles of 'institution' and 'community'.

[15] G. Eghigian, "Deinstitutionalizing the History of Contemporary Psychiatry," *History of Psychiatry* 22, no.2 (2011): p.203. Original emphasis.

[16] See John Welshman's apt historiographical summary. J. Welshman, "Rhetoric and Reality: Community Care in England and Wales, 1948-74," in *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000*, ed. P. Bartlett and D. Wright (London: The Athlone Press, 1999), p.205. His discussion covers the contributions of Kathleen Jones, Andrew Scull, Peter Sedgwick and Joan Busfield.

[17] There is also comment on the removal of the judiciary from the certification process – initially seen as positive or progressive as it lessens the 'custodial' implications and foregrounds 'therapeutics', as well as making 'mental illness' more like 'physical illness' by taking Magistrates out of treatment arrangements. This aspect is brought to even more prominence when discussing the Mental Health Act (1983), which is conventionally analysed in a pair with the 1959 Act; 1983 functions as the 'lawyers' revenge', reasserting a legal (civil rights-infused) role for the judiciary in mental treatment. See L.O. Gostin, *A Human Condition: The Mental Health Act from 1959 to 1975: Observations, Analysis and Proposals for Reform* 2vols., vol. 1 (London: National Association for Mental Health, 1975); ———, *A Human Condition: The Law Relating to Mentally Abnormal Offenders: Observations, Analysis and Proposals for Reform* 2vols., vol. 2 (London: National Association for Mental Health, 1977). For an overview of the machinations behind the 1983 Act see R. Bluglass, "The Origins of the Mental Health Act 1983: Doctors in the House," *Psychiatric Bulletin* 8, no.7 (1984).

The standard narrative of integration, described in the introduction, runs almost seamlessly from the Mental Treatment Act (1930), through the NHS (1948) to the Mental Health Act (1959). Charles Webster participates in this conventional story, casting the 1959 Act as a process of 'tying up loose ends' left by the NHS in the march towards (presumably) fully integrated, comprehensive healthcare. He argues that 'the major loose end that was left by the NHS was the law relating to lunacy, and this was duly undertaken in 1959, following the Royal Commission on the Law relating to Mental Illness and Mental Deficiency.'[18]

This Commission (the Percy Commission) publishes its report in 1957, which contains the clearest and most widely circulated statement that psychiatry should become integrated with 'general medicine'[19]: '[d]isorders of the mind are illnesses which need medical treatment... most people are coming to regard mental illness and disability in much the same way as physical illness and disability.'[20] It is stated in the text of the Mental Health Act, 1959, that '[n]othing in this act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital'.[21] This further relaxation of the technicalities of admission is an important part of the rhetorical efforts at equivalence, as the common location makes a transformation of 'physical injury' into 'psychosocial disturbance' easier. Barbara Wootton demonstrates the sheer number of groups that are rhetorically committed to the integration of mental and physical medicine during the 1950s, citing evidence submitted to the Percy Commission. This includes testimony on behalf of the Association of Municipal Corporations ('it is now agreed that mental illness is a medical condition requiring the same amount of care as any other medical condition') and the Royal College of Physicians ('the procedure for treatment of the mentally ill should approximate as far as possible to that of the physically ill'). The County Councils Association make 'suggestions for "accelerating" the "process of gradually placing the treatment of medical or physical illness on a similar footing"' and the Association of Psychiatric Social Workers takes it as read that to bring 'the treatment of nervous and mental disorders more closely in line with that of physical

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[18] Webster, "Psychiatry and the Early N.H.S.," p.104. A.K Ross, legal commissioner on the board of control from 1954 elaborates upon the internal logic linking the processes in the NHS and the Mental Health Acts: 'When you had local authorities running the institutions, it was argued, it was desirable to have a central body… Now that the Minister of Health was in charge there was no need to have a second Government department acting as a kind of watchdog.' H.L. Freeman, "In Conversation with A.K. Ross," *Psychiatric Bulletin* 16, no.4 (1992): p.195.

[19] The 1959 Act has been discussed in detail by Rogers and Pilgrim, *Mental Health Policy in Britain*; Lester and Glasby, *Mental Health Policy and Practice*.

[20] Baron of Newcastle Percy, "The Report of the Royal Commission of the Law Relating to Mental Illness and Mental Deficiency," (London1957). The *NAMH Guide to the Mental Health Act 1959* opens by quoting this paragraph in its entirety. A.L. Hargrove, *N.A.M.H. Guide to the Mental Health Act 1959*, Rev. ed. (London: N.A.M.H., 1963), p.2.

[21] "Mental Health Act, 1959," (London: HMSO, 1959), p.3.

illness' is a positive step.[22] Wootton is clearly justified in stating that '[t]he wish to assimilate the treatment of mental and physical illness is thus widely supported'.[23]

'Attempted suicide' fits with the 'equivalence' thread more than the 'community' narrative. This equivalence is broadly attempted by providing for the treatment of 'mental disorders' *in the same places* as for 'physical disorders' – general hospitals. This process, and its significance for mental healthcare in Britain, is not prominent in the historiography relative to 'asylum to community' narratives[24]; these are largely incompatible with the present account of the rise of 'attempted suicide as cry for help'. This is because, whilst one of the ideas behind this shift is that mental disorder is an interpersonal, socially mediated disturbance (something which *is* relevant to the type of scrutiny focused upon 'attempted suicide' in this period[25]), the transformations that undergird 'attempted suicide' happen in general hospitals, which are neither asylums nor 'the community'. In the vast majority of the cases analysed in this thesis, it is the *uncontroversially physical* aspect of 'attempted suicide' that first brings it to medical attention (it does not bridge the 'psychosomatic' gap in the same way as a 'peptic ulcer' or 'effort syndrome', for example). Even when arguing that all attempted suicides should be investigated by a psychiatrist in 1963, Stafford-Clark remarks that it 'has surely never been suggested' that 'general physicians were to be wholly excluded from the management of these cases.'[26] Neil Kessel notes in 1965 that 'it is as a general medical problem that the poisoned patient first presents.'[27] This management, be it surgical or toxicological, is something which, as seen in the introduction, is not performed in, or particularly relevant to 'the community'.

It is vital not to conflate processes of 'integration' with those of 'decarceration' or moves towards 'community care'. Whilst these schemes have informality of admission as a common factor, they are not the same thing. Maclay argues that '[t]he whole philosophy of the Mental Health Act is that care and treatment for the "mentally disordered" will normally be obtained informally, in the same way that it is obtained for other medical and surgical conditions.'[28] Because it makes little sense to claim that surgery or resuscitation (for example) is performed 'in the community', the emergence of a psychiatrically-inflected 'attempted suicide' in the

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[22] Wootton, *Social Science and Social Pathology*, pp.208-209.

[23] Ibid., p.209.

[24] Richard Mayou writes that '[g]eneral hospital psychiatry has had a long history, but one that has been neglected by both historians and psychiatrists. In the 20th century, the care of major mental illness has returned to the general hospitals.' Mayou, "General Hospital Psychiatry," p.774.

[25] See chapter four.

[26] D. Stafford-Clark, "Attempted Suicide," *The Lancet* 281, no.7278 (1963): pp.448-449. Two of the other participants in this correspondence argument are Neil Kessel and Richard Asher; the correspondence was initially sparked by an Erwin Stengel article.

[27] Kessel, "Self-Poisoning (2)," p.1340.

[28] Maclay, "British Mental Health Service," p.5.

second half of the twentieth century in Britain cuts across the canonical story of 'decarceration' in mental health.

Ad hoc referrals, eclectic clinicians and limited scrutiny

This wider rhetoric of integration informs a number of idiosyncratic and ad hoc practices that bridge the separate regimes of general and mental medicine. A number of studies of 'attempted suicide' are carried out in the late 1950s at general hospitals but not in observation wards. These can show the varied ways in which therapeutic regimes are negotiated, and physical injuries turned into psychosocial disturbances to varying degrees. Robinson observes in 1961 that 'the more progressive hospitals had anticipated [the Mental Health Act's] provisions, and the more reactionary had not yet started implementing them.'[29] Whilst the late 1950s and early 1960s seem to represent the rhetorical height of integration, the picture is much messier in terms of practical arrangements and clinical objects. One such little-publicised practical arrangement exists at Sheffield Royal Infirmary where from 1951 guidance is in place to ensure that all 'attempted suicides' are assessed by a psychiatrist.[30] The difference between broad integrative sentiment and local difficulties in bridging the practical divide is also important, and militates against too close a focus upon the retractions of the 1959 Act (as opposed to pro-active integrative policy).[31] Clinical psychiatric objects are not produced only by rhetorical effort and broad, overarching policy shifts. What remains key, even as the focus of the thesis shifts toward more macro-level changes, is the intellectual, practical, interpretive labour that *inscribes* this 'attempted suicide' into casualty records, *undercuts* the significance of somatic injuries and *constructs* a psychosocial environment around it.

Clinicians Middleton, Ashby and Clark conduct a survey between 1953-7 from the casualty departments of a hospital group in Gateshead. They relate that '[i]n 145 cases [of 219, 2/3] we have a psychiatric report on the patients. In many other cases the patients were transferred directly to a mental hospital'.[32] This is a specific crossover mechanism, and partially as a result of this psychiatric scrutiny, they comment that '[t]here can be little doubt that in many cases

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[29]K. Robinson, "Comment" (paper presented at the Emerging patterns for the mental health services and the public, Church House, Westminster, London, 09.03.61-10.03.61 (1961)), p.97.

[30] According to a letter sent from the (Sheffield) Royal Infirmary to the Ministry of Health in 1961: '[a]s long ago as 12th November 1951 the Board accepted a recommendation of its Mental Health Advisory Committee that in all cases of attempted suicide it was advisable for the patient to be seen by a psychiatrist before leaving hospital'. Letter dated 12.04.1961 in MH137/384 at National Archives. Stengel does not mention this arrangement when he writes that '[i]n the Sheffield teaching-hospitals, written Instructions… posted conspicuously… forestalled the circular of the Ministry of Health by four years' (i.e. 1957) Stengel, "Attempted Suicide: Management," p.234.

[31] For detailed reviews of the act, see C.W. French, *Notes on the Mental Health Act 1959* (London: Shaw, 1967); S.R. Speller, *The Mental Health Act 1959* (London: The Institute of Hospital Administrators, 1961). For more recent historiographical treatment Rogers and Pilgrim, *Mental Health Policy in Britain*.

[32] G.D. Middleton, D.W. Ashby, and F. Clark, "An Analysis of Attempted Suicide in an Urban Industrial District," *The Practitioner* 187(1961): pp.777-778.

suicidal attempts are little more than "gestures" seeking to draw attention to the patient's difficulties… 36 per cent of our patients required not only psychiatric opinion but mental hospital admission.'[33] They see mental hospitals as appropriate places for treatment, rather than provision at a general hospital. There is a similar awareness of 'gestures', but no deeper investigation is carried out that is necessary in order to fabricate and establish the centrality of a 'social field'. However, they mention social factors in a general sense, arguing that 'stronger family ties, better family life, less domestic strife due to financial difficulties, precipitated by excessive expenditure... would also cut down the numbers of psychoneurotics making abortive suicidal gestures.'[34]

Three of the above points require emphasis. First, the casualty department shows its administrative or sorting function. Second, this function – for some classes of patient, in some hospitals – provides space for psychiatric and general medicine to co-exist, through a 'psychiatric report'. Third, psychological scrutiny connected to this space can make visible certain kinds of motivations around 'attempted suicide'. However these motivations either appear ephemeral, tending towards the shallow, folksy analysis born out of cursory attention, or imported from the sociology of 'completed suicide' rather than the psychiatric social work of 'attempted suicide'.

PSW Moya Woodside works at Guy's Hospital in London during the 1950s (having co-authored *Patterns of Marriage* (1951) with Eliot Slater). She opens her 1958 study of attempted suicide at Guy's with the rather gloomy appraisal that attempted suicides 'present special medical and administrative problems in a general hospital. Their admission may be regarded with disfavour, treatment may be narrowly confined to their physical condition, provision for aftercare or psychiatric investigation haphazard or ignored.'[35] In this short passage, Woodside neatly encapsulates the problems that stem from the separated therapeutic approaches: the negative attitude of general physicians to 'self-inflicted' injuries, and the dominance of one therapeutic regime – the treatment of physical injuries. These 'problems' hinder the psychiatric scrutiny that is necessary to sustain the 'cry for help'.

The remedy for Woodside is not an observation ward, but a psychiatric department: '[i]f the hospital has a psychiatric department, the reception and disposal of these ['attempted suicide'] patients is more likely to be conducted in accordance with the needs of their mental

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[33] Ibid.: p.781.
[34] Ibid.: p.782.
[35] M Woodside, "Attempted Suicides Arriving at a General Hospital," *British Medical Journal* 2, no.5093 (1958): p.411.

state.'[36] Guy's is reasonably well-equipped in this regard. Before the Second World War, R.D. Gillespie received 'a large anonymous benefaction, which he brought to Guy's for a department of psychiatry. The York Clinic opened with 45 beds in 1944, initially as an emergency medical service hospital for officers, and then with a mixture of private and public beds.'[37] In 1948, at the inauguration of the NHS, only fifteen of forty-one beds are public.[38] Its atmosphere is described by J.J. Fleminger, arriving in 1955, as 'not merely comfortable – it was charming'.[39]   The clinic offers 'acute treatment, out-patient services, and consultations both on general wards and in the casualty department.'[40] These practices are crucial in overcoming the 'problems' of psychiatric scrutiny in general hospitals.

High levels of effort are required, especially with records from casualty departments which are routinely seen as insufficiently detailed for the 'attempted suicide' sought. Woodside makes no special arrangements for her 'attempted suicide' study. She admits '[n]o interviews were undertaken with any patient, nor were they followed up after discharge',[41] but she does utilise the 'full psychiatric histories' and 'follow-up scheme' of the predominately private York Clinic. The three groups studied are subject to different intensities of scrutiny. The first group consists of 'attempted suicides' admitted to A&E in 1957 and then transferred to an observation ward or voluntarily to a mental hospital (10). The second group arrive at A&E in the same year and are then admitted to general wards (24). The last group combines the 1956 and 1957 direct admissions to the York Clinic (11 and 10 respectively), which are 'grouped together to give a number comparable to that of the general ward admissions.'[42]

The group admitted to A&E and then transferred to a mental hospital or observation ward cannot be investigated adequately due to record quality in A&E. When analysing the 'precipitating stress of the suicidal attempt' this is only 'so far as could be judged from the scanty information available.'[43] A&E again appears (unsurprisingly) as thoroughly inadequate to sustain an interpersonal psychiatric object. The second group of records (those transferred from A&E to the general wards) are described as 'much less detailed [than the York Clinic] and occasionally incomplete.'[44] However this group does contain '[f]uller notes [than] those in

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[36] Ibid.

[37] Mayou, "General Hospital Psychiatry," p.770.

[38] E. Jones, "War and the Practice of Psychotherapy: The U.K. Experience 1939-1960," *Medical History* 48, no.4 (2004): p.505.

[39] Ibid.

[40] Mayou, "General Hospital Psychiatry," p.770.

[41] Woodside, "Attempted Suicides," p.411.

[42] Ibid.: p.412.

[43] Ibid.: p.411.

[44] Ibid.

group 1, and their social background could be more adequately analysed'.[45] Higher intensity (fuller notes) segues into social background. Thus under 'precipitating stress', '[s]ocial factors appeared to predominate: they frequently overlapped, or were found together with depressive states.'[46] Social factors here include isolation, drunkenness 'followed by marital rows with violence' debts, unemployment and housing conditions.[47] 'Attempted suicide', transferred out of the 'scanty' scrutiny of A&E, becomes more socially embedded.

Of the York Clinic admissions it is found that '[i]n comparison with groups 1 and 2, psychiatric rather than social factors were predominant.'[48] This is unsurprising as this third group 'had been selected to some extent by a previous contact with the clinic or by an obvious psychotic illness requiring psychiatric care.'[49] This is the only group which sustains a separate section on their 'characteristics', which has a markedly interpersonal focus: '[t]hese patients, on the whole, were vulnerable immature people. They showed marked emotional instability, low tolerance for stress, and an inability to handle personal relationships.'[50] This is also a very domestic focus, which might be expected, given the historical development and skill set of PSWs: '[t]hey involved themselves in divorce (4 out of the 20 had had previous marriages dissolved), in unsatisfactory pre- and extra-marital affairs, in marital strife and jealousy.'[51] These are not connected to 'alcohol' as they are in the previous group of 'social factors'. Crucially there is also an 'appeal' aspect visible: '[t]heir life histories often showed a pattern of immature hysterical behaviour, and at least four of the attempted suicides in the group appeared to be of a histrionic attention-compelling nature.'[52] The sort of evidence required for the maintenance of this psychiatric object requires something more than just general hospital wards, and preferably a well-resourced institutional basis for psychiatry inside a general hospital.

Also at Guy's 'attempted suicide' is seen as a distinct clinical entity in the work of J.J. Fleminger (who works at the York clinic in the 1950s and surveys psychiatric referrals from surgery and general practice in the 1960s) and B.L. Mallett (who publishes on psychosomatic pathology and psychogeriatrics). Whilst working under Stafford-Clark, Fleminger and Mallett argue that '[r]egarding all our clinical findings, we believe that they are only representative of general hospital work. Substantially different figures may be expected from studies confined to

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[45] Ibid.: p.412.
[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Ibid.
[50] Ibid.: p.413.
[51] Ibid.
[52] Ibid.

particular departments of medicine or surgery which emphasize different psychiatric problems.'[53] This is crucial appreciation of how particular contexts form distinctive fields of visibility. They survey 'all new referrals of inpatients for psychiatric advice at Guy's Hospital during the 5 years from July, 1955' which bring to their attention '[t]hirty-six patients... taken into hospital as a result of suicidal attempts'.[54] This group is seen as a result of 'a psychiatric unit [that] has been well established'[55] at Guy's, and are also labelled '[p]sychiatric disorder (including suicidal attempts)'. They claim that 'although they were in a coma or some degree of physical distress at the time of admission, the psychiatric basis of their condition had soon been recognized.'[56] Again, the physical basis is appreciated first in patients conveyed to hospital, with the psychiatric soon after. This sequence of recognition forms the basis of the need for transformation and crossover between regimes.

Richard Asher and 'pseudocide'

Another late 1950s emergence of 'attempted suicide' occurs at a site connected to an observation ward, but not strictly from inside it. This happens at the Central Middlesex Hospital, in a report by John Edward Lennard-Jones and Richard Asher. Asher's wider work in and around this observation ward during the 1950s and 60s demonstrates how liminal hospital spaces and eclectic, idiosyncratic interests bring diverse new clinical objects to light. His involved negotiations around 'mental' and 'physical' symptoms also show how difficult it is to bridge the psych-soma separation in general hospital environments without wider impetus. Further, his work shows how psyche-soma interaction does not only produce one class of object (injuries explained through psychosocial, complex intent).

Asher is an erudite, eclectic and eccentric physician, prolific throughout the 1950s, and as famous for his flamboyant writing style as he is for his naming of 'Munchausen Syndrome'[57] and his forceful critique of 'bed rest'.[58] He carries out much of his clinical research from the observation ward at the Central Middlesex Hospital (CMH). He associates himself with this ward so strongly[59] that he resigns from all medical practice when it is reassigned from his (physician's) control to a psychiatrist in 1964 (this reassignment coincides with Denis Hill's time

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[53] Fleminger and Mallett, "Psychiatric Referrals," p.189.

[54] Ibid.: p.185.

[55] Ibid.: p.183.

[56] Ibid.: p.185.

[57] R.A.J. Asher, "Munchausen's Syndrome," *Lancet* 257, no.6650 (1951). Named as such because of the 'similarity between the wanderings and fabrications of the patients he [Asher] described and the travels and fantastic anecdotes related by or attributed to Baron Munchausen' J.C. Barker, "The Syndrome of Hospital Addiction (Munchausen Syndrome) a Report on the Investigation of Seven Cases," *The British Journal of Psychiatry* 108, no.453 (1962): p.167.

[58] R.A.J. Asher, "Dangers of Going to Bed," *British Medical Journal* 2, no.4536 (1947).

[59] He has already been quoted referring to it as 'my own mental observation ward' Asher, "Arrangements for the Mentally Ill," p.1266.

as head of the academic Department of Psychiatry at the CMH). It is even said that the 'personal tragedy'[60] of losing 'his ward' contributes to his death by suicide five years later.[61] John Edward Lennard-Jones is a medical registrar at the Central Middlesex Hospital in 1959; he later becomes, under the guidance of gastroenterologist Francis Avery Jones, an eminent specialist in that field.[62]

Asher and Lennard-Jones coin the term 'pseudocide' in 1959, to describe people 'who deliberately harm themselves or take an overdose of tablets without wishing to die'.[63] The clinical sample underlying this research consists of '34 consecutive patients whom we saw in the general wards of our hospital; we excluded patients with obvious mental illness admitted to the mental observation ward.'[64] They then exclude the 12 deemed 'serious', leaving only those deemed 'doubtful' and 'spurious'.[65] An observation ward seems to contribute to a medical space that is particularly receptive to drawing psychiatric inferences from 'physically injured' patients; in the case of 'attempted suicide' these seem (again) to focus around 'intent': '[i]n our experience, of those admitted to hospital alleged to have attempted suicide, one in three did not want to die. They were not cases of attempted suicide; we call their performance "pseudocide" – a monstrous word which we would gladly relinquish if we knew as good a current one.'[66]

The following illustrations show quite how 'socially embedded' these attempts are, and how much questioning is necessary to situate them in this way. Under '[d]oubtful suicide attempts' they set out a detailed case-study description of a social situation, both before and after the 'attempt':

> 'A Hungarian girl, aged twenty, took 15 aspirins because she felt lonely when her Irish boy friend did not visit her at the weekend, and had been offhand when she telephoned him. She took the aspirins impulsively and was glad when she came to no harm. Next day a solicitous boy friend escorted a smiling girl from hospital.

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[60] K.P.B. and G.D., "Obituary Notices: R.A.J. Asher," *British Medical Journal* 2, no.5653 (1969): p.388.

[61] B.M.T. Rowat, "Richard Asher and the Seven Sins of Medicine," *Humane Medicine Health Care* 1, no.2 (2001).

[62] The field of gastroenterology has its own particular relationship with the boundaries between general medicine and psychiatry (peptic ulcers, 'busman's stomach', constipation, etc. etc.). Avery Jones edited the first collection of Asher's writing published after his death. R.A.J. Asher and F.A. Jones, *Richard Asher Talking Sense* (Edinburgh: Churchill Livingstone, 1972).

[63] J.E. Lennard-Jones and R.A.J. Asher, "Why Do They Do It? A Study of Pseudocide," *Lancet* 1, no.7083 (1959): p.1140.

[64] Ibid.: p.1138.

[65] Ibid.

[66] Ibid.: p.1140.

Comment: Suicide may have entered her mind, but the appeal value of her action was enormous.'[67]

Under 'Spurious Suicide Attempts', they bring preceding and subsequent social situations to relevance again:

'An Irish maid of twenty, working in a hotel, gave in her notice and was due to leave the next day. Having no friends in England and only a week's wages she felt that desperate action was needed. She swallowed a bottle of aspirins and then, having told the manageress what she had done, she undressed and went to bed. The doctor, urgently summoned, found her sitting up in bed combing her hair, but as he entered the room she fell back groaning… *Comment*: A silly girl who liked showing off.'[68]

These descriptions are folksy and idiosyncratic, whilst still drawing on Asher's undoubted interest in some form of social psychology. The intent in these cases is articulated through commonsense ideas of communication: 'appeal value' and 'showing off'.

Despite the casual tone, the practices used to elicit these objects are remarkably labour-intensive. The tripartite division (serious, doubtful and spurious attempts) is only possible 'after carefully, and sometimes repeatedly, questioning patients and their relatives'.[69] Whilst formal observation ward admission might not be essential for the visibility of 'attempted suicide', the connection and exchange mechanism that such wards institutionalise between psychiatry and general medicine makes it unsurprising that a certain configuration of a 'cry for help' might emerge in the work of Asher, whose interests and available facilities render transformations across the boundary particularly likely.

Instead of seeing 'pseudocide' as psychosocial, it is more precise to label it 'psychosomatic' for it is part of a much wider series of negotiations between physical and psychological medicine at the Central Middlesex Hospital, principally articulated through Asher's interests in psychosomatic medicine. His famous 'Munchausen's syndrome' is concerned with patients attending hospital with 'physical' symptoms for which there are often fantastical explanations given by the patient; psychopathology (and 'self-infliction' of wounds) is inferred, on a diagnostic journey from 'somatic' symptoms to psychopathology.[70] Asher claims that '[t]he

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[67] Ibid.: p.1138.
[68] Ibid.: pp.1138-1139.
[69] Ibid.: p.1138.
[70] Asher, "Munchausen's Syndrome." R.A.J. Asher, "Munchausen Syndrome," *British Medical Journal* 2, no.4950 (1955). It has been described by Ruth Holland as an 'inspired choice of name for the extraordinary desire of some people to undergo unnecessary operations and their fabrication of tall

patient showing the syndrome is admitted to the hospital with apparently acute illness supported by a plausible and dramatic history… Usually the patient seems seriously ill.'[71] It takes a large amount of effort from many different sources to produce a 'Munchausen's' diagnosis: '[e]xperienced front-gate porters are often invaluable… Often the police are found to know the patient… Gradually the true history is pieced together.'[72] He diagnoses such patients as 'hysterics, schizophrenics, masochists or psychopaths of some kind' and seeks 'a cure of the psychological kink which produces the disease.'[73] It requires significant effort to cross between the positions of 'physical condition' and 'psychopathology': '[m]ost cases resemble organic emergencies… [the] acute abdominal type… haemorrhagic type… neurological type'.[74] 'Munchausen's' is expressed as a baffling form of deception that does not quite fit the established category of 'malingering': '[u]nlike the malingerer, who may gain a definite end, these patients often seem to gain nothing except the discomfiture of unnecessary investigations or operations.'[75] Thus it is differentiated from malingering because there seems to be no conscious *intent* to gain (or to escape) anything in particular. Just as Batchelor and Napier's recasting of 'attempted suicide' does not fit securely with notions of 'intent' due to damage inflicted by childhood emotional deprivations,[76] clear notions of intent do not fit 'Munchausen's syndrome' and the action is rooted in a 'psychological kink' (which does not attempt to make it otherwise comprehensible).

When treating certain patients with psychotic symptoms (also associated with observation wards[77]) Asher thanks 'the visiting doctors and magistrates who left cases uncertified so that I could keep them for thyroid treatment rather than transfer them to a mental hospital.'[78] Treatment in observation wards is clearly still contentious. Asher's forceful charisma allows him to negotiate a pre-1959 system that only permits 'mental' and 'general medical' boundaries to be blurred for a short time of observation, especially where potentially 'dangerous' psychoses are concerned.[79] As seen in chapter one, the observation ward can normally only keep patients for seventeen days before they need to be transferred to mental

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stories of baroque complexity to achieve this end.' 'Introduction' to R.A.J. Asher and R. Holland, *A Sense of Asher: A New Miscellany* (London: British Medical Association, 1984), pp.xii-xiii.

[71] Asher, "Munchausen's Syndrome," p.339.

[72] Ibid.

[73] Ibid.: pp.339, 341.

[74] Ibid.: p.339.

[75] Ibid.

[76] See chapter two.

[77] Michael Shepherd mentions 'a ward that was full of acute psychotic patients, like the old observation ward at St Francis' Wilkinson, *Talking*, p.231.

[78] R.A.J. Asher, "Myxoedematous Madness," *British Medical Journal* 2, no.4636 (1949): p.562.

[79] See also, Asher 'The physical basis of mental illness' published in the *Medical Society's Transactions* vol. LXX, 1953-54, reprinted in Asher and Holland, *A Sense of Asher: A New Miscellany*, p.34.; R.A.J. Asher, "Backache as a Psychosomatic Manifestation," *The Practitioner* 179, no.1070 (1957). and ———, "Malingering," *Transactions of the Medical Society of London* 75(1959).

hospitals or released.[80] Asher complains: 'I can issue a fourteen-day order (section 21a) and keep the patient in my ward for a fortnight, but if I want to keep a patient longer than that… I have no legal way of doing so… I cannot issue a fourteen-day order unless the authorised officer has first issued a three-day order.'[81] This shows how difficult it is to keep patients under extended scrutiny in observation wards. It is precisely these difficulties that are removed by the 1959 Act and the shift to DGH psychiatric units.

Asher's *interests* are seen to negate this split between any given patient's 'psychic' and 'somatic' treatment needs despite these legal obstacles. During rather sour correspondence about whether *all* 'attempted suicides' should be seen by a psychiatrist (a position to which Asher is implacably opposed), Seymour Spencer (an Oxford psychiatrist at the Warneford Hospital) argues that 'the general physician of Dr. Asher's psychiatric inclinations'[82] is sufficient to treat 'attempted suicides', revealing that Asher is seen as a particularly 'psychological' physician. Asher writes to George Godber on this issue in 1962, enclosing a memorandum about the management of 'attempted suicide'. He claims that 'I do not believe that each and every case needs to be seen by a psychiatrist. What is needed in most cases is a reasonable amount of understanding of human behaviour and everyday problems, and also tolerance and kindness without credulity, gullibility or excessive sentimentality.'[83]

As well as reinforcing his commonsense, folksy approach to psychological problems this may also indicate a reason why 'pseudocide' fails to gain traction: it is not conceptualised in such a way that it needs institutionalised, professional therapeutic crossover that enables durability and sustained coherence (even though Myre Sim, as late as 1981, still thinks the term 'attractive, not only because it bears the hallmark of a good pun, but because it accurately interprets the patient's intention'[84]). It is notable that Asher does not see the phenomenon as a particularly psychiatric problem, and indeed resists the 'total' claims of psychiatrists upon it. The failure of 'pseudocide' can also partially be explained through Asher's resignation given that the crossover significantly draws upon his personal, varied interests. The extra scrutiny required to sustain this object on anything other than a 'rarities' scale (like Munchausen's patients, for example), makes 'pseudocide' a somewhat impractical object.

However, it is also important to avoid placing too much explanatory weight upon Asher's personal eclectic interests as the site of these negotiations between separated therapeutic

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[80] See chapter one.
[81] Asher, "Arrangements for the Mentally Ill," p.1265.
[82] S. Spencer, "Attempted Suicide," *Lancet* 281, no.7277 (1963): p.448.
[83] Asher, Richard 'A Memorandum on the Management of Attempted Suicide Cases' dated 18.10.1962 , TNA: PRO: MH 137/384.
[84] M. Sim and J. Donnelly, *Guide to Psychiatry* (Churchill Livingstone New York, 1981), p.430.

regimes. The observation ward, and its association with potentially 'dangerous' patients, is not the only factor that might influence enquiry towards socially embedded explanations for 'attempted suicide'. The Medical Research Council's (MRC) Social Medicine Research Unit under the direction of Jerry Morris (with Richard Titmuss as statistician) is sited at the Central Middlesex Hospital from 1949 until 1956.[85] The academic psychiatry unit there, opened in 1961, is the first in London and Denis Hill, its first Professor, places 'special emphasis on consultation and liaison services to the rest of the hospital.'[86] A.H. Crisp (who follows his mentor Hill to the Middlesex in 1961[87]), uses this referral scheme to study anorexia nervosa, another condition founded on psychic-somatic interplay.[88]

Birmingham and Hartlepool: miscellaneous arrangements

Moving out of special wards or clinics, but continuing the theme of local, practical arrangements that negotiate between psychological and general medical expertise is an article by the Birmingham-based J.A. Harrington and K.W. Cross. They report an ad hoc – but effective – set of practices from a general hospital that enables systematic psychiatric scrutiny of cases arriving at A&E. Their investigation into 'attempted suicide' is based upon a specific arrangement: '[t]he medical and surgical consultant staff in charge of these [accident and emergency] wards were specially requested to refer all their cases of attempted suicide for psychiatric assessment. Their co-operation did much to facilitate the investigation.'[89] Harrington and Cross further elaborate that '[a]ll the cases were personally examined by one of us [Harrington]; data were recorded on a statistical form which was evolved after a pilot study... Where possible, independent evidence from relatives and other sources was obtained, and cases for which clear-cut information was not obtained were seen for out-patient follow-up or on transfer to psychiatric units.'[90] All these are distinctive and specific arrangements (pilot study, new statistical practices, follow-up) that bring different kinds of scrutiny to bear on patients brought to A&E. Most importantly, the practice of obtaining information from relatives is crucial in achieving one of their stated aims: 'to relate an attempt at suicide to significant psychiatric, ecological, cultural, and other factors.'[91]

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[85] After 1956, the unit transfers to the London Hospital S. Murphy, "The Early Days of the MRC Social Medicine Research Unit," *Social History of Medicine* 12, no.3 (1999): pp.394, 404.

[86] Mayou, "General Hospital Psychiatry," p.771.

[87] G. Russell, "Arthur Hamilton Crisp," *Psychiatric Bulletin* 31, no.4 (2007): p.157.

[88] A.H. Crisp, "Some Aspects of the Evolution, Presentation and Follow-up of Anorexia Nervosa," *Proceedings of the Royal Society of Medicine* 58, no.10 (1965); ———, "Clinical and Therapeutic Aspects of Anorexia Nervosa - a Study of 30 Cases," *Journal of Psychosomatic Research* 9, no.1 (1965).

[89] J.A. Harrington and K.W. Cross, "Cases of Attempted Suicide Admitted to a General Hospital," *British Medical Journal* 2, no.5150 (1959): p.463.

[90] Ibid.

[91] Ibid.

Key here are '[s]pecific inquiries [that] were made into the childhood background and family history in each case', which enabled Harrington and Cross to construct and bring to relevance 'an emotionally disturbed and unhappy childhood... separated from one or other parent, or from both parents, before the age of 14 years.'[92] However, instead of solely rooting the 'attempt' in childhood deprivations, they also link it to substantially present-centred concerns, arguing that:

> '[a]cute interpersonal conflict was important and immediately preceded the suicidal attempt in 41% of cases, this factor being twice as common in women... In about a quarter there appeared to be no intention to die, but a hope of achieving some other aim, notably a change in attitude of another person in close relationship to the patient. In 63% of the patients the attempt appeared to be impulsive and unpremeditated.'[93]

They conclude with the claim that '[w]hile a few cases show no psychiatric illness requiring treatment, all attempts at suicide require psychiatric investigation.'[94] Thus through a special referral arrangement with medical and surgical staff, interviewing relatives and out-patient follow-up, a patient seen at A&E because of physical injury can have the significance of that injury related to emotional disturbance in childhood; it can also become a symptom of, and a response to 'acute interpersonal conflict'[95] – transformed into a discernibly psychiatric object. Thus both the approach of Batchelor and Napier, focusing upon childhood, and the present-centred concerns of Stengel and Cook coexist. Myre Sim, whose *Guide to Psychiatry* goes to a fourth edition, works at Birmingham with Harrington and Cross. He references them in a chapter on 'The Psychiatric Aspects of Poisoning' (1961) as emphasising 'inter-personal problems such as husband-wife disagreements, broken romances and the like.' He then undercuts that analysis by claiming that 'all motives yielded by patients should be seen in the light of dream interpretation – a manifest content and a latent content, and it is the latter which is frequently more significant.' [96] Thus for Sim, the evidence yielded by those practices remains explicitly subordinate to the internal psychodynamics of the patient's personality. Different types of scrutiny yield different objects.

Finally, J.V. Nicholson's study of 'self-inflicted and accidental poisoning' from the Hartlepools Group Hospitals, though published in 1963, can show how pre-1959 psychiatric scrutiny might enable the emergence of a psychosocial 'attempted suicide'. He is clear about the difficulty of

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[92] Ibid.: p.466.

[93] Ibid.: pp.466-467.

[94] Ibid.: p.467.

[95] Ibid.: p.464.

[96] G. Cumming, *The Medical Management of Acute Poisoning* (London: Cassell, 1961), p.115.

negotiating therapeutic regimes for these particular cases, given their initial 'presenting symptom': '[a]lthough the General Hospital has an acute mental health unit with beds, lack of staff and facilities make it unsuitable for the admission of acute cases of poisoning, which in their initial treatment are a medical rather than a psychiatric problem.'[97] He comments that '[a]ttempted suicide introduces other factors: an effort, conscious or unconscious, to draw attention to difficulties, or even pure exhibitionism.'[98] Whilst his whole series covers 1946-61, these characteristics in particular become visible only around the time that certain 'specialist help' in mental assessment is available to the group of hospitals in Hartlepool. He claims that '[b]ecause of the shortage of specialist help up to 1957 it has been impossible to make any firm diagnosis of the mental state of the patients in the [whole] series and no attempt has been made to survey this aspect.' Tellingly, 'it does appear that in the last five years [i.e. 1957-1961] there has been an increase in young persons dramatizing what appear to outsiders as minor difficulties such as a failure of a girl or boy friend to keep an appointment, thwarted love affairs and family quarrels.'[99] Young people with 'minor difficulties', 'family quarrels' and 'love affairs' come to light at the same time as psychiatric specialist help is provided to the casualty departments of general hospitals. This is more clear evidence not only of the difficulties of switching between therapeutic regimes, but also of the kinds of objects that emerge through this transformative shift.

Thus in Gateshead, at Guy's and the Central Middlesex in London, in Birmingham and in Hartlepool, 'attempted suicide' emerges through diverse practices. These practices enable transfer between separated therapeutic regimes, either in the form of referral between hospital departments, special arrangements, or even based around eclectic clinicians associated with observation wards. The object appears with increasing frequency, and yet the varied practices that negotiate the split between general and psychological medicine makes these 'attempted suicide' objects seem like so many miscellaneous, disconnected occurrences. There is certainly not much sense from the articles surveyed that 'attempted suicide' is a huge problem. The exception is Nicholson, published latest (1963), who notes a 'great increase' in the past seven years. The potential for an epidemic is clearly there, but it requires much more national-level coordination and intervention to be fully realised.

It again requires intensive psychological scrutiny across these varied practices in order to root the transformed physical injury in a social space, achieved by the growing fluidity and interaction between separated therapeutic approaches under comprehensive healthcare

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[97] W.A. Nicholson, "Self-Inflicted and Accidental Poisoning in Adults Admitted to a General Hospital," *Practitioner* 190(1963): p.233.
[98] Ibid.: p.231.
[99] Ibid.: p.232.

provision. In short, as the provision of mental healthcare is rethought and reconstructed in the late 1950s, new objects appear. It has already been argued that too great a fixation on 1959 is unhelpful because it removes restrictions that are somewhat irrelevant – in one sense – because this particular phenomenon presents first as 'physical injury'. The 1959 Act *does not* enact integration, it merely removes legal obstacles. Thus analysis of broader trends allied with specific studies is clearer than a forensic focus on the passage and provisions of the Act. Whilst the 1961 'retraction' of the law around suicide is similar in one sense, the Government is much more pro-active, prescriptive and practical, so the Suicide Act repays this kind of closer scrutiny.

Suicide Act 1961: complex intent, legal reform and government intervention

Rhetorical and practical efforts to integrate psychiatric and general medicine in district general hospitals further enable a clinical phenomenon of 'attempted suicide as cry for help'. The second legislative shift in this chapter involves the decriminalisation of 'suicide' and 'attempted suicide' achieved by the Suicide Act 1961. Whilst this marks a decisive end to some longstanding medico-legal debates around suicide it does not substantially change police *practice* which, since 1916 in the Metropolitan area and 1921 nationwide, had broadly been *not* to charge.[100]

Several legal reform arguments bring complex intent to prominence, and the resulting 'retraction' of the law initiates a far-reaching shift, enabling an openness and formality around the medical and psychiatric treatment and recording of 'attempted suicide'. After the Act is passed, the Ministry of Health is prepared to intervene to recommend that *all* cases of 'attempted suicide' seen at casualty or by GPs are considered for *referral for psychiatric assessment* on a national scale. This positive intervention thus multiplies the possibilities for the (re)articulation of this phenomenon. Rates of psychiatric referral of 'attempted suicide' are actively followed up, policed and collated by the Ministry of Health; hospital groups have to account for any significant number of patients not directed to psychiatric scrutiny. The rhetoric around 1959 encourages integration, but these developments *prescribe* crossover, fuelling the growth of this phenomenon from a 'limited number' to an 'epidemic'.

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[100] For the 1916 Order, see: 'Crime, General Orders. Suicides – Attempted' , TNA: PRO: MEPO3/2436. Home Secretary Gwilym Lloyd George announces in 1956 that '[a]s long ago as 1916 the Metropolitan Police adopted… the practice of preferring a charge of attempted suicide only where there is no responsible person able or willing to take charge of the individual concerned, or where special circumstances, such as threats of renewed attempts of suicide or positive indications of insanity suggest that the individual should be kept in custody for his own protection. In 1921 the Metropolitan practice was brought to the notice of provincial forces.' HC Deb 20 December 1956 vol 562 col 1432.

The Suicide Act as a tale of two conflicts: Hart/Devlin and Butler/Macmillan

The Suicide Act of 1961 has yet to receive sustained attention from historians. It is instead seen as a minor part of the clutch of legislative changes and government reports seen to constitute the first 'permissive moment' in post-1945 Britain, under the reforming Conservative Home Secretary Richard Austen Butler, between 1957 and 1962. (The second of these 'moments' concerns Roy Jenkins' time at the Home Office, which Jenkins himself recalls as 'the Liberal Hour' in his autobiography.[101]) Butler's time at the Home Office sees discussions around 'how far to liberalise social constraints (if at all), particularly in relation to gambling, licensing, Sunday observance, suicide, censorship and the law governing sexual behaviour.'[102] These discussions play out against the intellectual backdrop of the most famous jurisprudential debate of the twentieth century, between Lord Patrick Devlin and Professor Herbert Hart.

The debate is sparked by the publication of the Wolfenden Report[103] in 1957 which recommends (among other things) that 'homosexual acts' be decriminalised between consenting adults in private. This debate snowballs into something much more general; in Peter Hennessy's apt summary, 'at issue was the power of the state to outlaw private practices it deemed immoral even if they harmed no one else.'[104] Devlin, a judge and later a Law Lord argues that the law should, indeed must, be involved with moral questions as there could be no theoretical limit to society's powers to police itself – that 'the criminal law could not operate without a moral law'.[105] Hart, a philosopher and Professor of Jurisprudence at the University of Oxford, counters that moral questions are outside the legitimate remit of the criminal law, unless they involve harm to another person (following such nineteenth-century liberal philosophers as John Stuart Mill). The Suicide Act of 1961 features explicitly in this debate, as Hart praises the decriminalisation of suicide as 'the first Act of Parliament for nearly a century to remove altogether the penalties of the criminal law from a practice both clearly condemned by conventional Christian morality and punishable by law.'[106]

Mark Jarvis' study of the reforming Conservative government of the late 50s and early 60s is subtle and discerning, but rather rushes through the reform of the law relating to suicide, allotting it fewer than three pages. The Act figures most prominently for Jarvis as site of personal/political tension, an opportunity for the expression of the differing political

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[101] R. Jenkins, *A Life at the Centre* (London: Politico's, 2006).
[102] M. Jarvis, *Conservative Governments, Morality and Social Change in Affluent Britain, 1957-64* (Manchester: Manchester University Press, 2005), p.6.
[103] Baron Wolfenden of Westcott, *Report of the Committee on Homosexual Offences and Prostitution* (London: HMSO, 1957).
[104] P. Hennessy, *Having It So Good : Britain in the Fifties* (London: Allen Lane, 2006), pp.505-506.
[105] Jarvis, *Conservative Governments*, p.11.
[106] Hart, quoted in Hennessy, *Having It So Good*, p.510.

dispositions of Butler and the then Prime Minister, Harold Macmillan. Although the Act is strictly out of the time period of Hennessy's *Having it So Good: Britain in the Fifties*, he uses the act in a very similar way.[107] Both analyses pivot around an exchange between Macmillan and Butler. Macmillan asks '[m]ust we really proceed with the Suicides [sic] Bill? I think we are opening ourselves to chaff if, after ten years of Tory Government, all we can do is to produce a bill allowing people to commit suicide.'[108] Butler counters that '[t]he main object of the Bill is not to allow people to commit suicide with impunity... It is to relieve people who unsuccessfully attempt suicide from being liable to criminal proceedings.'[109] For Jarvis, this emphasises 'a wider sense of tension between the Home Secretary and Prime Minister... In his flippant attitude to reform of the suicide law, the Prime Minister showed how detached he had become from social reform, and antagonised Butler with his lack of insight at a time of major change.'[110] Hennessy prefaces the exchange with the contention that 'Macmillan's detachment, verging on insouciance, really irritated Butler.'[111]

Both accounts do go beyond the accessible and human narrative around personalities to make this exchange, and the Act, function explicitly as a site for the Hart-Devlin debate. Jarvis argues that 'in the case of the law governing suicide, Butler had modernised regulation by shifting it from a religious basis towards a more clearly defined border between law and private morality'.[112] This fits in perfectly with what Jarvis sees as the attitude at the very top of the Conservative Party motivating these legislative changes: in Macmillan's words, that people could 'be trusted to do more of what is right.'[113] Thus the Suicide Act analysis forms part of his claim that '[t]his debate obviously had an impact on the Conservative Party'.[114] For Hennessy, more succinctly, this exchange shows that 'Butler was, by nature and intellect, in the Hart camp.'[115]

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[107] In fact, Hennessy credits Jarvis for 'bringing Macmillan's memo and Butler's reply to my attention.' Ibid., p.711.

[108] Macmillan to Butler, 24.06.1961 TNA: PRO: PREM 11/3241 Jarvis, *Conservative Governments*, p.95; Hennessy, *Having It So Good*, p.510.

[109] 'Suicide and Attempted Suicide: Proposals to Amend Law' Draft Reply Macmillan to Butler TNA: PRO: HO 291/141 Jarvis, *Conservative Governments*, p.95; Hennessy, *Having It So Good*, p.510. However facetious Macmillan appears to Butler, he is not alone in failing to appreciate the link between the law on suicide and the treatment of 'attempted suicide'. (Lord) Lewis Silkin admits that he is unaware 'from the Bill itself that it is intended to cover also attempted suicide.' HL Deb 02 March 1961 vol 229 cols 253-254.

[110] Jarvis, *Conservative Governments*, pp.95-96.

[111] Hennessy, *Having It So Good*, p.510.

[112] Jarvis, *Conservative Governments*, p.98.

[113] Ibid., p.1.

[114] Ibid., p.12.

[115] Hennessy, *Having It So Good*, p.510.

Although both Hennessy and Jarvis accept that the Suicide Act is much more than a barometer of personal tension between Macmillan and Butler, they both place the issue of suicide law reform firmly in the context of the Hart-Devlin debate, making it function as a jurisprudential and parliamentary expression of moral libertarianism. This obscures much of its complicated resonance. Instead of positioning it within a programme of 'liberal reforms', or as a barometer of political instincts (liberal utilitarianism versus moral paternalism) lurking beneath party political rivalries (reformist Home Secretary versus traditionalist Prime Minister), or even as an expression of a celebrated jurisprudential debate, the analysis here shows how the Act initiates changes in hospital and (to a lesser extent) police practices, setting in train processes that enable, constitute and sustain a specific 'epidemic' of attempted suicide.

Stengel, legal reform and complex intent

The roots of the 1961 Act can be most clearly seen – purely in parliamentary terms – in the repeated questions of Kenneth Robinson, Labour MP for St. Pancras North, whose richly varied reforming political career involves being the first Chairman of the National Association for Mental Health, Minister for Health in the Labour Government of 1964-1968, sponsor of a Private Member's Bill to legalize abortion in 1961 and member of the Homosexual Law Reform Society's Executive Committee.[116] Robinson begins asking questions of Butler on February 6th 1958. Butler's initial response is that he is 'not satisfied that any change in the law is desirable'. When Robinson counters that 'considerable and growing opinion in the medical and legal professions, and among the general public' is in favour of a change, Butler neatly refocuses the issue away from medical and legal professionals, and onto what he imagines to be much safer ground: 'the present concept of suicide as a crime has its roots in religious belief'.[117]

Robinson's reference to 'growing opinion' denotes a late 1950s surge in debates around the law on suicide. This includes Glanville Williams' *The Sanctity of Life and The Criminal Law* (1958), the British Medical Association and Magistrates' Association Committee's (BMA-MA) second report in just over a decade (1958) (having also produced a memorandum on suicide law in 1947) alongside a contribution from the Anglican Church, *Ought Suicide to be a Crime?* (1959). A brief look at these and other texts shows that as well as being explicitly influenced by Stengel's work, legal arguments in favour of reform promote visions of complex and contested intent driving 'suicidal actions'.

Against this model, perhaps the earliest post-war contribution in favour of decriminalisation – that the sanction of the law is no deterrent because that person concerned expects to be dead

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[116] L.M. Jeger, "Robinson, Sir Kenneth (1911–1996)," in *Oxford Dictionary of National Biography* (Oxford: O.U.P., 2006).

[117] HC Deb 06 February 1958 vol 581 col 1327.

– implies an 'attempted suicide' modelled upon 'genuine' intent. The British Medical Association's (BMA) 1947 memorandum, prepared by their Committee on Psychiatry and the Law, explicitly downplays the significance of communicative or 'hysterical' attempts:

> 'Whether the prospect of police court proceedings is in any way a deterrent to the would-be suicide is a question which may be asked. Except in respect of hysterics whose motive, though they may not be aware of it, might be to attract attention, the large majority of those who attempt suicide do so in the expectation of completing the act. Thus it is probably true to say that would-be suicides are not likely to be deterred by fears of police court proceedings, since they believe they will be dead before the issue arises.'[118]

The power and significance of the 'deterrence' argument in this case is connected to debates circulating at that time about the non-deterrent effect of the law on capital punishment.[119] Although 'hysterical' attempts are downplayed in the context of these arguments about decriminalisation, there is still an acknowledgement that suicidal intent can be complicated.

Glanville Williams, eminent legal scholar and conscientious objector to the Second World War, publishes his 'highly controversial' text *The Sanctity of Life and The Criminal Law* in 1958, which ranges widely, examining 'the philosophical basis for laws against contraception, sterilization, artificial insemination, abortion, suicide, and euthanasia'.[120] His arguments for the decriminalisation of suicide are noted by the Home Office and in Parliament, adding considerable intellectual muscle to reform arguments.[121] His position shows how the concept of 'attempted suicide as cry for help' can complicate (and critique) the law in a new way. That is to say, that the 'cry for help' gains traction in the law reform movement because this concept is used to undermine the law, with questions of 'intent' again prominent. Williams' section on '[t]he nature of attempted suicide' argues that '[m]uch light has been shed upon this matter, which is of great potential importance in the administration of the criminal law, by

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[118] B.M.A. Committee, "Attempted Suicide," p.103. One of the arguments advanced by a Church of England booklet (see below) is similar: '[t]he punishment of the offender is not likely to deter others from attempting to commit suicide, if only because they will be confident of success.' Office, *Ought Suicide?* , p.10. Note the use of 'would-be suicide' in a context that implies earnest, uncomplicated intent.

[119] A clause for the abolition is contained in the Criminal Justice Bill (1949), passed in the commons but defeated in the Lords. As a result of this, a Royal Commission on Capital Punishment is established (1949-53).

[120] R. Spencer, "Williams, Glanville Llewelyn (1911–1997)," in *Oxford Dictionary of National Biography* (Oxford: O.U.P., 2004).

[121] Williams' letter to *The Times* on 26.02.1958 sparks an influential exchange which is referenced in both Houses of Parliament. See Kenneth Robinson, HC Deb 31 October 1958 vol 594 col 522, Lewis (Baron) Silkin, HL Deb 16 March 1961 vol 229 col 980. The letter is in the Home Office file on the Suicide Law, TNA: PRO: HO 291/141.

a recent medical study made by Professor E. Stengel and Miss Nancy Cook.'[122] He also draws upon Lindsay Neustatter's *Psychological Disorder and Crime* (1953). One of Neustatter's examples in which the police *will* take action and prefer criminal charges is when 'repeated attempts have been made, and it is evident that these are not genuine, but due to sensation-mongering: e.g. a girl several times threw herself down into shallow water where she could not possibly drown'.[123] Williams' keen legalistic analysis brings out a tension in the law's operation, that '[i]f an attempt is not seriously intended, it is not, in law, an attempt, and neither a prosecution nor a conviction is justified. There is no crime of attempted self-manslaughter by knowingly running the risk of death.'[124]

Part of Williams' critique of operation of the criminal law is thus based upon his reading of Stengel and Cook. He argues that 'what may be generically called "suicidal acts" are of three kinds', the 'genuine', the 'demonstrative' and the intermediate 'gamble', which is 'consciously an attempt at suicide, but unconsciously a gesture.'[125]

> 'The three kinds of suicidal acts call for separate consideration from a legal point of view. Genuine attempts at suicide are offences under present English law. Suicidal demonstrations are not, as such, offences. The legal status of the third group is undetermined; indeed, no court has yet had to pronounce upon unconscious motivation in criminal law. It seems probable, however, that such motivations, even if proved to the satisfaction of the court, will be ignored, on the ground that legal sanctions can only deal with the conscious mind.'[126]

Whilst only one of the three categories is deemed ineligible through Williams' mobilisation of Stengel and Cook, the complex-motivation 'attempted suicide' popularised, publicised and stabilised by Stengel and Cook has specific traction in the reform arguments. In Williams' hands it involves a statement that the law as it stands is *not relevant* to a 'gestural' kind of 'attempted suicide' in any case. A leading article in the *BMJ* in 1958 uses the work of Williams and Stengel to support the claim that: '[t]he fact that in some cases the person has no real intention of killing himself has incidentally led to the curious position by which convictions for attempted suicide take place "where there is no legal foundation for them in the evidence,

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[122] G.L. Williams, *The Sanctity of Life and the Criminal Law: On Contraception, Sterilization, Artificial Insemination, Abortion, Suicide and Euthanasia* (London: Faber & Faber, 1958), p.253.
[123] Ibid., p.250. quoting W.L. Neustatter, *Psychological Disorder and Crime* (London: Christopher Johnson, 1953), p.68.
[124] Williams, *Sanctity of Life*, p.250.
[125] Illustrating the 'demonstration' category, Williams quotes Neustatter's description of 'a gesture by a patient suffering from a bad depression, calling upon the world to take notice of his misery'. Ibid., p.255.
[126] Ibid.

properly considered."'[127] Whilst this does not strictly *undermine* the law, it certainly critiques the interpretation and application of it.

Geoffrey Fisher, the Archbishop of Canterbury, forms a Church of England Committee chaired by his direct successor as headmaster of Repton public school, J.T. Christie.[128] This committee issues the booklet *Ought Suicide to be a Crime?* in 1959.[129] (A key member of the committee is Doris Odlum who, as a psychiatrist and magistrate (and later a president of The Samaritans), also sits on the joint BMA-Magistrates' Association committee.) The booklet is written in three parts, with distinctly legal, psychological and religious arguments marshalled in turn.[130] In the legalistic section there is the argument that undercuts the law's application, as in Williams' and Neustatter's analyses: '[t]he man who repeatedly throws himself under a 'bus is plainly a public menace, but there cannot be many such men... It is doubtful whether, as a matter of law, anyone can be properly convicted of attempted suicide unless it is proved that he or she intended to kill themselves.'[131] Again, the law is seen to be of ambiguous relevance when 'intent' is scrutinised. Even the section that approaches the question from a 'moral' or 'religious' angle invokes an elastic notion of a 'complex mental history' to question the idea of intent: '[m]uch more is now known about suicidal tendencies and about the complex mental history that can characterise a potential suicide. It would seem as if there are not many suicides which can nowadays be regarded as wholly voluntary and deliberate.'[132]

Psychiatric advances are mobilised to question whether a legal response is appropriate: '[a]s a result of the development of psychiatry, it can be granted on all sides that many cases of suicide and attempted suicide should never be legally assessed at all, nor religiously condemned. They are indeed amoral.'[133] This 'development of psychiatry' is probably a reference to the removal of legal formalities in the 1959 Mental Health Act. As a speech in the House of Lords on this bill in July 1959 shows, the issues of suicide and mental health law reform are connected, as 'one of the commonest kind of mental patients coming before the

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[127] "Felonious Suicide," *British Medical Journal* 1, no.5081 (1958): p.1225.

[128] Christie is headmaster of Repton (1932-1937) and Westminster (1937-1950) schools, and Principal of Jesus College, Oxford (1950-1967) A.L.P. Norrington, "Christie, John Traill (Rev.)," in *Oxford Dictionary of National Biography* (Oxford: O.U.P., 2004).

[129] Office, *Ought Suicide?*.

[130] Part one ('The Law of Suicide and Attempted Suicide') predominantly written by Rupert Cross, Fellow and Tutor in Law of Magdalen College, Oxford; part two ('A Consideration of Psychological Factors Involved in Suicide and Attempted Suicide') written predominantly by Doris Odlum; part three ('Suicide: A Moral and Religious Assessment') by the Rev. Canon I.T. Ramsey, Nolloth Professor of the Philosophy of the Christian Religion in the University of Oxford. Ibid., p.3.

[131] Ibid., p.12.

[132] Ibid., p.21.

[133] Ibid., p.22.

court... the attempted and unsuccessful suicide'.[134] The focus of (what becomes) the Mental Health Act 1959 on the relationship between legal sanction and psychiatric treatment might bring 'attempted suicide' to prominence in a context where that action is still against the law. Thus law reform arguments can bring complicated or ambiguous intent around 'suicidal actions' to new prominence.

Returning to the Parliamentary passage of the bill, on March 6th, 1958, Robinson informs Parliament that he has obtained over 170 signatures to a motion for reform of the suicide law. He argues pointedly that his motion had been signed by those 'of all shades of religious opinion'. Butler again attempts to deflect rather than deal with the issue directly suggesting that '[i]f the Opposition would wish to find time on a Supply Day for this or any other similar general question, it would be an interesting subject for the House to discuss.'[135] Undeterred, Robinson submits a question a week later, asking 'on what evidence he bases the view that amending legislation to remove suicide and attempted suicide from the list of criminal offences would not be generally acceptable to public opinion.' Rather testily, Butler's reply is that '[e]xperience suggests that changes in the law on matters which involve religious and moral issues are likely to be contentious.' However, he is publicly more open about the possibility for legislative change, adding that 'I have not closed my mind on this Question and am continuing to study it carefully and sympathetically.'[136]

At the end of May, Robinson applies more pressure, mentioning the Memorandum issued by the Joint BMA-MA Committee[137]; in October, he criticises the law on the grounds that it is no deterrent: '[c]learly, the fact that suicide or attempted suicide is an offence against the law has very little, if any, effect on the mind of the would-be suicide.'[138] Butler directs the Criminal Law Revision committee to look into the practical aspects of changing the law in 1959[139] and

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[134] In this speech Lord Taylor bafflingly genders 'attempted suicide' by running it together with a gendered version of infanticide: 'A deeply depressed patient who is committed for attempted suicide or infanticide or attempted infanticide is remanded for trial in a prison. Should that patient be given electrical convulsive treatment before she is tried—it is usually a lady? I do not know what the right answer is.' HL Deb 01 July 1959 vol 217 col 599.

[135] HC Deb 06 March 1958 vol 583 col 1342.

[136] HC Deb 13 March 1958 vol 584 col 74W.

[137] HC Deb 22 May 1958 vol 588 col 1471.

[138] HC Deb 31 October 1958 vol 594 col 523 Again, note the association of 'would-be suicide' with 'genuine' intent.

[139] It is a small – but important – point that this committee does not *recommend* a change in the law (as Jarvis asserts. Jarvis, *Conservative Governments*, p.95.). It is asked to investigate the practical changes that would need to be made on the basis that the law concerning suicide is to be abrogated, whilst retaining the offences around assisting, suicide and suicide pacts. The terms of reference are exceptionally precise and restrictive, and of a very practical nature. 'I have asked the Criminal Law Revision Committee to consider, on the assumption that it should continue to be an offence for a person—whether he is acting in pursuance of a genuine suicide pact or not—to incite or assist another to kill or attempt to kill himself, what consequential amendments in the criminal law would be required

Robinson keeps up the pressure asking oral and written questions about the progress of the Committee eight times, something he later characterises as part of 'three years' Parliamentary nagging'.[140] The bill is introduced in the Lords on 14th February 1961 and is finally enacted on 3rd August that year.

Stengel and Statistics: between 25,000 and 40,000 'attempted suicides'

A number of '25,000-30,000 suicide attempts' in England and Wales is consistently deployed in these parliamentary debates. This number is produced by combining very different kinds of numbers, but shows how Stengel influences the debates. In *Attempted Suicide* (1958) it is considered 'clearly absurd' that similar totals of 'suicides' and 'attempted suicides' are registered in Metropolitan Police Statistics.[141] In 1952 Stengel considers it 'quite clear from everyday experience that suicidal attempts greatly outnumber suicides.'[142]

This supposedly 'clear absurdity' guides the search for a substitute, which is found in the obscure *Statistical Bulletin* of The Metropolitan Life Insurance Company of New York. The article 'Suicides that Fail' (1941) states that more than 18,000 people kill themselves per year in the United States, and that 'probably another 100,000 make unsuccessful attempts' which 'would be equivalent to a ratio of rather less than six attempted to one completed suicide.'[143] This ratio is taken from 'the Police reports of Los Angeles and Detroit since data of this kind were not available for other cities'.[144] Stengel, Cook and Kreeger are admirably honest about their ignorance of Los Angeles and Detroit, stating that 'it has not been possible to ascertain what methods of registration are at the disposal of the authorities in the American cities mentioned' and it is the 'absurdity' of the Metropolitan Police figures for attempted suicide that underpins the statement that the American figures 'appear to be much more realistic'.[145] This ratio of 6:1 is transposed onto the *London* suicide rate, creating a figure of 4,332 suicide attempts to the 722 recorded suicides. However, in the Parliamentary debates on the Suicide Bill, a ratio of 6-7:1 is used in a different way, applied to the Registrar General's suicide rate for

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if it were decided that suicide and attempted suicide should no longer be criminal offences.' HC Deb 26 November 1959 vol 614 col 61W.

[140] The 'nagging' comment is in a speech on HC Deb 14 July 1961 vol 644 c843. The oral and written questions about the progress of the Bill and the Criminal Law Revision Committee take place on HC Deb 06 November 1958 vol 594 cols 94-5W; HC Deb 26 February 1959 vol 600 cols 1276-7; HC Deb 16 April 1959 vol 603 cols 1120-1; HC Deb 23 July 1959 vol 609 col 142W; HC Deb 05 November 1959 vol 612 cols 1190-1; HC Deb 26 November 1959 vol 614 col 61W, HC Deb 28 January 1960 vol 616 cols 358-9; HC Deb 10 November 1960 vol 629 col 72W.

[141] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.31. See also TNA: PRO: MEPO 2/6955.

[142] Stengel, "Enquiries into Attempted Suicide [Abridged]," p.614.

[143] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.31.

[144] Ibid.

[145] Ibid.

England and Wales of c.5,000, and multiplied up to make an estimate of '30,00-40,000 'attempted suicides'.

In June 1958 Walter Maclay circulates a memorandum claiming that the death rate from suicide in England and Wales is 12 per 100,000 of the population. From this, he concludes that suicide 'causes more than 5,000 deaths yearly'.[146] This figure of 5,000 is widely accepted during Parliamentary debates. In October 1958, Kenneth Robinson claims that 'Each year there are about 5,000 suicides, and slightly more attempted suicides known to the police… the vast majority of attempted suicides never become known to the police. The estimated total is somewhere between 30,000 and 40,000.'[147] Robinson takes the suicide figure and multiplies it by Stengel's ratio of six or seven. A memorandum presented to the Home Affairs Committee in 1959 states that '[i]t is estimated that some 30,000 suicidal attempts occur every year'.[148] Cabinet minutes in 1960 record an identical statement.[149] Throughout debates on the Suicide Bill, numbers of this order are repeated. In 1961 Viscount Kilmuir (David Maxwell-Fyfe) refers to 25,000 attempts[150] as does Lord (Lewis) Silkin[151] and the Bishop of Carlisle mentions 'upwards of 30,000 men and women who have attempted suicide and have failed… 30,000 people, distraught in mind and soul'.[152] In July 1961 in the House of Commons, Leo Abse mentions 'the 5,000 suicides and the 25,000–30,000 attempted suicides which unfortunately take place annually.'[153] Glanville Williams also uses Stengel's ratio, and is explicit about its provenance.[154] This number of 25,000-40,000 is *not* pushed by Stengel. He applies the ratio of 6-7:1 to the number of suicides known to the Police *in the Metropolitan Police District*. This ratio is used by others in a different context, and creates a memorable number around which the campaign for law reform crystallises.

Tom Waidzunas' article 'Young, Gay and Suicidal' (2012) notes how '[q]uite frequently, statistics… travel without citation, conveying alarm in a compact and memorable

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[146] W.S. Maclay [?] 'Suicide' dated 30.06.1958 , TNA: PRO: MH 137/383. Presumably Maclay uses a population figure of 45,000,000, meaning 5,400 suicides from 12 per 100,000. It is unclear where Maclay finds this figure as Norman Kreitman comments (in 1972) that the suicide rate for England and Wales throughout the 1950s is approximately 14 per 100,000. N. Kreitman, "Suicide in Scotland in Comparison with England and Wales," *British Journal of Psychiatry* 121, no.560 (1972): p.83.

[147] HC Deb 31 October 1958 vol 594 col 521.

[148] 'Cabinet – Home Affairs Committee – Suicide and Attempted Suicide' 04.06.1959 [meeting on 29.07.59] TNA: PRO: MH137/383.

[149] 'Cabinet – Suicide and Attempted Suicide' 24.10.1960 TNA: PRO: HO291/141.

[150] HL Deb 02 March 1961 vol 229 cols 248-249.

[151] HL Deb 02 March 1961 vol 229 col 256.

[152] HL Deb 02 March 1961 vol 229 col 258.

[153] HC Deb 19 July 1961 vol 644 col 1409.

[154] Williams, *Sanctity of Life*, p.244.

declaration'.[155] He invokes Bruno Latour who 'describes ''black boxing'' as the process by which facts become constructed, moving from qualified to unqualified claims.'[156] Such a process of 'black boxing' is apt to describe the ways in which the number of 30,000 attempted suicides gains traction – becomes 'compact and memorable' – in the debates on suicide law reform and more broadly. In the absence of other credible numbers either collected by police or clinicians – due to the legal position of 'attempted suicide' – Stengel's ratio combines the credibility of professorial expertise, and a sense that it is absurd for the numbers for 'attempted' and 'completed' suicide to be similar. This number is an uneasy combination of the Registrar General's suicide statistics with a ratio between 'suicide' and 'attempted suicide' from a New York insurance company based upon police records from Detroit and Los Angeles. It passes largely unnoticed that the ratio is brought to prominence in the creation of 'non-absurd' attempted suicide statistics from the (London) Metropolitan Police District, and gains publicity having been transposed onto the Registrar General's figures for England and Wales. However, the number finds its way onto a Hospital Memorandum (considered next) which leads Stengel to comment that '[t]he figure of 30,000 quoted in the Ministry's circular, which is about six times the number of suicides, is based on observations made in the United States and in this country, and is most probably an underestimate.'[157] It does not appear that Stengel has a problem with how his work is being used.

Hospital Memorandum HM(61)94 – Prescribing referral between therapeutic regimes

After 'attempted suicide' is officially decriminalised in August 1961, the Ministry of Health issues Hospital Memorandum HM(61)94 'Attempted Suicide' in September, with 'commendable speed'.[158] It asks 'hospital authorities to see that all cases of attempted suicide which come to their notice receive adequate psychiatric care.'[159] 'Attempted suicide' is again shown to be inextricably bound up with the integration of and negotiation between separate therapeutic regimes, from the acute, somatic medicine of Casualty departments to 'psychiatric care'. However, no extra resources are provided to casualty departments to enable this referral. In any case, similar to the previous chapter's analysis of A&E, the *intensive scrutiny*

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[155] T. Waidzunas, "Young, Gay, and Suicidal: Dynamic Nominalism and the Process of Defining a Social Problem with Statistics," *Science, Technology & Human Values* (2011): p.200.

[156] Ibid.: p.208. quoting Latour's *Science in Action* (1987).

[157] Stengel, "Attempted Suicide: Management," p.233. He raises the ratio further, to 8:1 ———, "Attempted Suicide: Management," p.233.

[158] E. Stengel, "The National Health Service and the Suicide Problem," in *The Sociological Review Monograph No.5: Sociology and Medicine: Studies within the Framework of the British National Health Service*, ed. P. Halmos (Keele: University of Keele, 1962), p.204.

[159] H.M. (61) 94 'Attempted Suicide' (18th September 1961) in Circulars letters notes and memoranda (1961) TNA: PRO: MH 119/15.

required for this object to flourish remains ill-suited to the administrative co-ordinating that occurs in 1960s casualty departments. Simply providing for 'referral' or 'crossover' is insufficient to produce a psychosocial 'attempted suicide', but it does attempt to coordinate referral on a nationwide (potentially 'epidemic') scale.

The idea behind HM(61)94 is first mentioned in correspondence between the Home Office and Ministry of Health on the final day of 1958. Earlier that year, Walter Maclay sends letters to a number of European and North American countries on behalf of the Department of Health to see how the issue of 'attempted suicide' is handled outside England and Wales. Patrick Benner, a senior civil servant within the Health Ministry synthesises these replies and sends a letter to the Home Office highlighting 'the difficulties which now sometimes arise… because the person who has attempted suicide does not always receive psychiatric advice'.[160] He continues that '[i]t would be up to us [Health Ministry] to try to remedy this by telling hospital authorities that whenever a case of attempted suicide is brought to a hospital, psychiatric advice should be obtained as a matter of routine'.[161] This is also stated at a Home Office-Health Ministry meeting in February 1959.[162] At a meeting between representatives from the Home Office, Health Ministry, British Medical Association and Magistrates Association it is again noted that

> 'in a great many cases the person would have been admitted to hospital to receive treatment for his physical injuries. At present, however, many of these persons were discharged without a psychiatric examination. The nature of the offence suggested that such an examination would be advisable in all cases, and Dr. Maclay said that this was a matter on which the Minister would be prepared to give guidance to hospitals.'[163]

The purpose of the memorandum is to ensure that the physically injured 'attempted suicide' patient obtains psychiatric assessment at general hospitals. Government intervention is needed to integrate the two therapeutic regimes that formally and legally become equal after the Mental Health Act 1959.

This cause receives extra impetus in November 1960 due to a report by the Royal Medico-Psychological Association (RMPA) on Casualty and Accident Services, by W. Linford Rees and John S. Stead. At this point, Rees is Chairman of the Research and Clinical Section of the RMPA,

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[160] Letter from P. Benner to Miss Nunn dated 31.12.1958 , TNA: PRO: MH 137/383.
[161] Ibid.
[162] Note for File by P. Benner dated 24.02.1959 , TNA: PRO: MH 137/383.
[163] Notes of Meeting at Home Office with H.O., Ministry of Health, Magistrates' Association and BMA, dated 13.03.1959 , TNA: PRO: MH 137/383.

having spent formative War years at Mill Hill, conducting research at the Effort Syndrome Unit,[164] the start of his 'pioneering work on psychosomatic disorders'.[165] He is remembered as facilitating 'the work of psychiatrists within the context of the general hospital'.[166] The report forms part of a more general early 1960s concern about casualty departments, which leads to the publication of a number of critical and anxious reports. (For example, in 1960 the Nuffield Hospitals Trust issue a report entitled *Casualty Services and their Setting: a Study in Medical Care*; a committee is set up under Harry Platt to investigate hospital casualty services that reports in 1962.[167])

Rees and Stead use '[i]nformation obtained by questionnaires sent to 49 general hospitals [which] revealed that, on the average, a casualty department dealing with 20,000 cases a year will deal with 150 to 200 cases of attempted suicide per year.'[168] They report that '[t]he psychiatric cases which casualty offers in casualty departments of general hospitals have to deal with fall mainly into three groups: - (a) Cases of attempted suicide. (b) Behavioural disorders including persons found wandering… (c) Patients with psychotic illnesses.'[169] The report is not positive about the care received: '[i]n only thirteen of the forty nine hospitals was the casualty officer able to call in a psychiatrist to advise on disposal'. More disturbingly, '[f]ew of the hospitals in the regions and few of the London teaching hospitals felt that they had adequate psychiatric advice available for assessment and appropriate disposal of patients.'[170] Rees and Stead have three recommendations, all concerned with the integration of psychiatric and general medical expertise in general hospitals, covering initial advice ('[t]he casualty officer should be able to call on psychiatric help for advice and disposal'), facilities for short-term psychiatric-diagnostic observation ('a busy casualty department should have two to four emergency beds for… further observation for a limited period, (i.e., a few days)'), and arrangements to transfer patients to either a psychiatric unit or psychiatric hospital ('facilities should be available for transfer… without undue difficulty or delay').[171] Concerns about the

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[164] W.L. Rees, "Physique and Effort Syndrome," *Journal of Mental Science* 91, no.382 (1945).

[165] "Obituary: Professor Linford Rees, Psychiatrist Who Brought His Subject into the Mainstream," *Independent*, 05.08. 2004.

[166]"Obituary: Professor Linford Rees," *Daily Telegraph*, 11.09. 2004.

[167] J. Fry, *Casualty Services and Their Setting: A Study in Medical Care* (Nuffield Provincial Hospitals Trust, 1960); Ministry of Health, "Accident and Emergency Services: Report of a Sub-Committee (Platt Report)," (London: HMSO, 1962).

[168] Report from Royal Medico-Psychological Association by W. Linford Rees and J.S. Stead: 'Report to Council on Casualty and Accident Services' dated 11.11.1960 , TNA: PRO: MH 137/383.

[169] Rees & Stead 'Report to Council' TNA: PRO: MH 137/383.

[170] Although patients were 'in many instances, referred to a psychiatrist later', 'the availability of psychiatric help in assessing the case is relatively infrequent.' Rees & Stead 'Report to Council' TNA: PRO: MH 137/383.

[171] Rees & Stead 'Report to Council' TNA: PRO: MH 137/383.

practicalities of integration – specifically the number of consultant psychiatrists – are also present in the 1958 BMA-MA Report.[172]

Wider integration and legal opportunity: common ground between 1959 and 1961

Arrangements for the memo are taken in hand later in November 1960, primarily because '[n]ow that the government have announced their intention of amending the [suicide] law… I think the time has come for us to issue a hospital memorandum urging hospital authorities to see that all cases of attempted suicide which reach them are given a psychiatric investigation.'[173] Benner adds that '[i]t seems all the more necessary to go ahead with this fairly soon in view of the recent report of the Royal Medico Psychological Association suggesting that this is a matter on which a good many hospitals are not doing very well.'[174]

The two broad reasons – the opportunity provided by a Government-sponsored bill to change the suicide law, and an appreciation that psychiatric advice in casualty departments is not all it should be – show up consistently in the memorandum negotiations and revisions. Instead of seeing the HM crudely, as solely enabled by the Suicide Act, it is acknowledged as significantly concerned with the wider integration promoted by the Mental Health Act 1959.

Benner writes to the Home Office on December 14th informing them that now 'the Government's intention of introducing legislation' has been announced, 'we thought that this would be a convenient moment for sending advice to hospitals.'[175] It is acknowledged that '[t]he general points we need to make to them are valid even in advance of the legislation'[176] because, 'our aim is to produce, in advance, the requisite degree of medical and social care.'[177] The Deputy Secretary is informed that '[i]t is for consideration whether to defer the issue of the H.M. [Hospital Memorandum] until the forthcoming Government Bill is enacted or at least more nearly so… There is, however, good reason to think that hospital practice is in need of improvement now and this depends in no way on the outcome of the [Suicide] Bill'.[178] Whilst part of MH(61)94 is prompted by the legal change, 'integration' of therapeutic regimes

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[172] 'One of the present problems is the shortage of consultant psychiatrists, and the committee recommends that careful attention should be paid to the extension of facilities as and when possible.' Joint Committee British Medical Association and the Magistrates' Association, "The Law and Practice in Relation to Attempted Suicide in England and Wales," (London: British Medical Association and Magistrates' Association, 1958), p.9. , TNA: PRO: HO 291/141.

[173] Note for File for Maclay by Benner dated 28.11.1960 , TNA: PRO: MH137/383.

[174] Ibid. It is invoked again, two months later. Note for Emery by Benner dated 13.02.1961 , TNA: PRO: MH 137/383.

[175] Letter from Benner to T.C. Green at the Home Office dated 14.12.1960 , TNA: PRO: MH 137/383.

[176] Ibid.

[177] Note for Dr. Macdonald from T.E. Nodder dated 03.01.1961, TNA: PRO: MH137/383 (This is mentioned in the context of advice to GPs, whose absence from the story is explained in chapter five.).

[178] Note from Emery to 'Deputy Secretary [of State for Health?]' Dated 15.02.1961 , TNA: PRO: MH 137/383.

(classed as 'improving hospital practice') is a significantly wider, independent issue. This is the shared territory between the 1959 and 1961 Acts.

Stengel takes a narrow legalistic line, rather than credit the Government with any serious acknowledgement that psychiatric facilities are inadequate in Accident and Emergency Departments. He writes that

> 'The role of the psychiatrist in the management of attempted suicide in the general hospital has for the first time been officially defined. Apparently, once the problem of suicide was taken out of the hand of the law, the Ministry of Health considered that the health authorities had to accept responsibility and to advise how it should be discharged.'[179]

The transformations in the previous chapter at observation wards are here promoted at accident and emergency departments. The potential for 'attempted suicide' to multiply onto a national, 'epidemic' scale is created. After 1961, the possibilities for the production of the clinical object 'attempted suicide as a cry for help' are transformed in size and scope, the foundation for a problem of epidemic proportions and national significance.

The text of the memorandum is centrally concerned with integrating psychological scrutiny into the overwhelmingly 'acute somatic' focus of casualty departments. It is stated that '[t]hese cases often come to hospital casualty departments for urgent lifesaving physical treatment… after physical treatment the patient is sometimes discharged without any psychiatric investigation of his condition [which is] of major importance in most cases of attempted suicide'.[180] It continues, offering suggestions that seem heavily influenced by Rees and Stead's report: '[h]ospital authorities are therefore asked to do their best to see that all cases of attempted suicide brought to hospital receive psychiatric investigation before discharge… Where the hospital has no psychiatric unit, it may be necessary to arrange for liaison with a neighbouring psychiatric hospital.'[181] Again, arrangements negotiating the split between psychiatry and general medicine (in this case 'liaison') are necessary for this clinical object to thrive. Stengel is sceptical as to whether total referral is achievable: 'it is doubtful whether the instructions concerning psychiatric advice and treatment can be fully implemented. There is hardly any hospital where *every* case of attempted suicide is seen by a psychiatrist.'[182]

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[179] Stengel, "Attempted Suicide: Management," p.233.
[180] H.M. (61) 94 'Attempted Suicide' TNA: PRO: MH 119/15.
[181] Ibid.
[182] Stengel, "N.H.S. And Suicide Problem," pp.204-205. Original emphasis.

However, he still does not see the potential for 'attempted suicide' to multiply exponentially because of the passing of the Suicide Act, instead focussing on coroners and 'completed suicide' figures: '[p]sychiatrists do not expect the law to lead to an increase in suicidal acts, but a slight rise in the suicide figures will not be surprising... some coroners may be less hesitant about giving a verdict of suicide rather than an open verdict.'[183] He does concede that

> '[i]t is also possible that the number of attempted suicides diagnosed as such in the hospitals may show a slight increase. If so, this should not be taken at its face value... Some hospital doctors were known to refrain occasionally from referring to the suicidal attempt in their diagnostic formulations, in case their patients should suffer inconvenience. For the same reason, the protestations of some patients that they had taken overdoses of dangerous drugs without suicidal intention may have been accepted too readily. Small increases in the numbers of suicides and attempted suicides in the next few years can therefore be regarded as artefacts.'[184]

The Ministry of Health also does not see this as a problem on a huge scale, as when the Hospital Memorandum is finally issued, it is decided not to alert the press because '[t]he documents are self-explanatory, and the subject, though important, is of limited scope.'[185] With hindsight, the foundations are there, but traditional ideas of 'incidence' obscure the epidemic potential from even the most vocal publicist for 'attempted suicide'.

Psychiatric Resources and Ministry follow-up

The A&E department is the site at which the Ministry of Health seeks to intervene, to entrench referral practices between therapeutic regimes. However, there are no extra resources provided for the proposed extension of psychiatric referral. Stengel optimistically believes that HM(61)94 will be a stimulus for the establishment of psychiatric outpatient departments and DGH psychiatric units, and social and community services in general:

> '[c]onsidering the large number of consultations required by the Ministry of Health [Hospital Memorandum]... The pressure for additional psychiatric staff and for the creation of more psychiatric outpatient departments is likely to increase. This will be all to the good because it will make the community aware of the inadequacy of the psychiatric services and will speed up plans for creating psychiatric departments in general hospitals. Thus, attempted suicide, that last

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[183] ———, "Attempted Suicide: Management," p.233.

[184] Ibid.

[185] Note to Mr. Dodds, Dr. Goodman & Deputy Secretary. From Benner[?] dated 03.08.1961 , TNA: PRO: MH 137/383.

and supreme appeal for help, may act as a powerful stimulus for the improvement of psychiatric and social services.'[186]

This again shows the link between the two Acts of Parliament analysed in this chapter. However, the idea that a newly decriminalised 'attempted suicide' might stimulate the integration of mental and general medicine is rather back-to-front. It is the much broader efforts attempting the integration of therapeutic regimes that enable this object to be constituted, that are *fundamental for the existence* of this 'supreme appeal for help'. S.W. Hardwick of the Royal Free Hospital writes to the Ministry and makes the same point as Stengel, that there are insufficient resources to carry out all these referrals: '[i]f I am right in my interpretation of the H.M., a considerable amount of additional work and responsibility will have to be undertaken by the Psychiatric Department, which may mean a requisition for extra staff.'[187] The Government's approach to integrating general and mental health in this specific case seems consistent with the broader (lack of) financial provisions around the Mental Health Act 1959. Stengel hopes that

> 'doctors and hospital authorities who have found the Ministry's recommendations impracticable will say so in no uncertain terms. It would be against the interests of patients to adjust the attempted suicide figures to the psychiatric resources available instead of adjusting the resources to the real demands.'[188]

Given the importance that is placed throughout this thesis upon the high intensity of scrutiny necessary for this 'psychosocial cry for help' to emerge consistently, casualty again seems like an unlikely candidate.

It is possible to glimpse the level of impact that the HM has on casualty services, because the Ministry of Health decides to follow up the recommendations. When the Joint Consultants Committee (an administrative body representing hospital consultants within the NHS) meets in June 1962, they request that the Ministry of Health 'take follow-up action with the [Regional Hospital] Boards to see that they had taken suitable action on HM(61)94.' Benner sends a note to government statistician G.C. Tooth[189] stating that whilst 'it is not our practice to follow up all H.Ms by any means… this is a rather important subject where I think some kind of action from

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[186] Stengel, "N.H.S. And Suicide Problem," p.205.

[187] Letter to 'Secretary' from Hardwick, dated 28.12.1961 , TNA: PRO: MH137/384.

[188] Stengel, "Attempted Suicide: Management," p.235.

[189] Tooth is most famous for the 1961 *Lancet* paper co-authored with Eileen Brooke 'in which it was claimed that… the future needs of beds in British mental hospitals would be halved, that is, from 3.4 per thousand to 1.8 per thousand of the population' N.S., "Eileen M. Brooke," *Psychiatric Bulletin* 13(1989): p.159. See: G.C. Tooth and E.M. Brooke, "Trends in the Mental Hospital Population and Their Effect on Future Planning," *Lancet* 1, no.7179 (1961). This is seen as launching Enoch Powell's *Hospital Plan* (1962) (see chapter five).

us would be reasonable.'[190] Benner fleshes out the 'importance' of the enquiry, arguing that '[q]uite apart from the Committee's request, I think that that the subject is sufficiently important to merit an enquiry – this, after all, is a problem which has been passed wholly to the health services, and it seems right that we should know how they are dealing with it.'[191] Tooth agrees, and notes that 'an important point would be the extent to which it has been possible to arrange for every patient to be seen by a psychiatrist before leaving the hospital after first aid treatment.'[192] Integration of psychiatric and general medicine for scrutiny of patients arriving at casualty is not simply prescribed, but actively policed after the change in the law.

Thus a letter is sent to all Regional Hospital Boards asking for the number of patients seen by a psychiatrist in the twelve months since the issue of the HM. Three principal questions ask for the 'approximate number of cases of attempted suicide admitted as in-patients or out-patients' during the last twelve months, the 'approximate proportion of cases which are seen by a psychiatrist' and 'brief details of any measures that have been taken to improve the arrangements for psychiatric investigation and follow-up.'[193] There are also two supplementary questions, and the Ministry concedes that although 'the information may not always be readily available', it would help if hospitals could indicate 'the approximate proportion of cases in which the psychiatrist considers that future care is needed, by way of either psychiatric treatment or supervision and help in the community' and also the proportion of those cases 'in which the necessary further care is successfully arranged.'[194] This is a concerted effort to prompt and shape casualty department practice. This information is collated and written up in an unpublished document in January 1964.[195]

The Ministry expresses broad satisfaction because although 'replies from Boards vary considerably… most managed to report that 75% of admissions were seen by psychiatrists.'[196] The memorandum prompts a number of diverse practical changes in various hospitals concerning psychiatric liaison. These are just glossed illustratively, to give a flavour of the different ways in which the therapeutic divide is constituted and negotiated in the same move. The Sheffield Regional Hospital Board (RHB) report that the Sheffield No.1 Hospital Management Committee (HMC) has the lowest rate of referral to a psychiatrist in that region

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[190] Note from P. Benner to G.C. Tooth dated 14.08.1962 , TNA: PRO: MH 137/384.

[191] Note by Benner for Mr. Emery dated 07.09.1962 , TNA: PRO: MH 137/384.

[192] Note from G.C. Tooth to P. Benner noted 15.08.1962 , TNA: PRO: MH 137/384.

[193] Circular letter 'Attempted Suicide' (Ref 94600/1/49b) dated 28.09.1962 , TNA: PRO: MH 137/384.

[194] Ibid.

[195] 'Attempted Suicide' in 'Attempted Suicide – Hospital Treatment and Replies to Questionnaire' TNA: PRO: MH 150/220.

[196] 'Attempted Suicide' , TNA: PRO: MH 150/220.

(65%). The hospital psychiatrist 'suggests a special form for all patients admitted for attempted suicide'[197] as a remedy. Grimsby HMC, under the same Board reports that '[s]ince HM(61)94 a rota of Mental Welfare Officers has been arranged whereby one sits in at each clinic and follow-up and all cases are referred to Consultant Psychiatrist in the Group.'[198] Under the North-West Metropolitan RHB, the Luton and Dunstable Hospital reports '[d]uring the last year the number of days on which there is a psychiatric out-patient clinic has increased from 2 to 3 a week, so that psychiatrist are more readily available to see these patients.'[199] Under the same RHB, Mount Vernon Hospital achieves only 35% referral and the psychiatrist concerned comments 'that unless he is relieved of some other commitments he will not have time to see all of the cases that should properly be referred to him.'[200]

This Board claims in its covering letter that '[w]here the information… shows a markedly inadequate service… the possibility of improvement [will] be discussed with the members of staff concerned.'[201] For the Wessex RHB '[t]he Board has taken action to bring the Salisbury Hospital group with a 39% return into line' and although the Isle of Wight reports that only 50% of cases have been psychiatrically assessed over the past year, '[i]n future all such cases will be seen by a Psychiatrist.'[202] These are uneven, ad hoc, idiosyncratic practices, despite the best efforts of the Ministry of Health. Referral arrangements involving Mental Welfare Officers and psychiatric out-patient clinics exist alongside new memoranda, renewed efforts at referral to psychiatric consultants and mental hospitals that, despite their differences, are all attempting to move towards integration.

The Ministry considers that '[t]he effect of our enquiry is particularly interesting' on the Welsh Board of Health, as it 'has resulted in a general overhaul of the procedure and the issue of a memorandum to be incorporated in future notes for the guidance of House Officers etc.'[203] However, the Cardiff RHB seems to have interpreted the guidance in such a way that the phenomenon of 'attempted suicide as cry for help' is as likely to be *excluded* as included in the returns: whilst 'every effort is made to ensure that a psychiatrist sees them ['attempted suicides']… discretion is given where trivial overdoses has [sic] suggested, presumably, the

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[197] 'Summary of Replies to questionnaire [Sheffield RHB] as the result of Ministry of Health letter 94600/1/49B dated 28th September 1962' enclosed with letter from Sheffield RHB to Ministry of Health dated 19.12.1962. TNA: PRO: MH 150/220 at National Archives. This form is possibly the one mentioned in Parkin & Stengel (1965) see chapter five.
[198] 'Summary of Replies to Questionnaire [Sheffield RHB]' , TNA: PRO: MH 150/220.
[199] 'North West Metropolitan Hospital Board – Treatment of Attempted Suicide' , TNA: PRO: MH 150/220.
[200] Ibid.
[201] Letter from North West Metropolitan Hospital Board to Ministry of Health dated 31.12.1962 TNA: PRO: MH 150/220.
[202] Letter from Wessex RHB to Ministry of Health dated 02.01.1963 , TNA: PRO: MH 150/220.
[203] 'Attempted Suicide' , TNA: PRO: MH 150/220.

possibility of accidental rather than systematic attempt at suicide.'[204] Not only does this show how administrative concerns impact upon diagnostics, it also shows that the instructions issued by the Ministry can also lead to a *decrease* in visibility for the phenomenon of 'attempted suicide as a cry for help.' Nothing is mechanistic or inevitable about these changes.

This is best illustrated by the fact that Stengel, who might be presumed to praise such state activity, thinks the statistical return less than useless. His letter to the Ministry of Health is unfortunately no longer in the file, but there remains a copy of one he sends to the Superintendent of the Royal Infirmary, Sheffield.[205] In it he argues that 'I have not been able to comply with your request… patients who have made suicidal attempts are not usually diagnosed as "attempted suicide" but under some other heading… The only way to provide the required information would be for the Ministry to request hospitals to put "attempted suicide" into the diagnostic index.'[206] He says that 'it would be a pity if the Ministry should accept information which cannot possibly be valid [and] dangerously misleading.'[207] This is a significant problem for the emergence of a consistent, epidemiological object of 'attempted suicide'.

This follow-up is still measured against the '30,000 attempts'. It is noted that '[r]eturns covered approximately 20,000 cases of attempted suicide out of an estimated 30,000 mentioned in the H.M.'.[208] The numbers come from totally different sources but the Ministry perseveres in equating them. Although there is 'no way of accounting for the difference… Professor Stengel pointed out in his letter… hospitals experienced some difficulty in identifying from existing records cases of attempted suicide.'[209] The 'discrepancy' is put down to the quality of the available records, rather than the fact that the numbers are produced in radically different ways. The 'estimate' is some 50% bigger than the 'actual number', yet still there are efforts to equate them.

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[204] 'Attempted Suicide [Welsh Hospital Board]' enclosed with letter from Welsh Hospital Board to Ministry of Health dated 21.01.1963 , TNA: PRO: MH 220/150.

[205] The Superintendent forwards it to the Sheffield Regional Hospital Board, who sends it to the Ministry of Health in lieu of the requested statistics.

[206] Letter from Stengel to Dunbar dated 14.09.1962 , TNA: PRO: MH 150/220. 'Diagnostic index' presumably refers to the one used for the Hospital In-Patient Enquiry (HIPE).

[207] He goes on to say that 'I am going to write to Mr. Benner to this effect and submit proposals about the best way of obtaining information about attempted suicide.' Letter from Stengel to Dunbar dated 14.09.1962 , TNA: PRO: MH 150/220. This letter is referred to in the file, as dated 30th January 1963, but does not appear to be there. Stengel mentions his forthcoming collaboration with Dorothy Parkin, which presumably acts upon these proposals, covered in depth in chapter five.

[208] 'Attempted Suicide' in 'Attempted Suicide – Hospital Treatment and Replies to Questionnaire' MH150/220 at National Archives.

[209] 'Attempted Suicide' in 'Attempted Suicide – Hospital Treatment and Replies to Questionnaire' MH150/220 at National Archives.

As Stengel's criticism states, without either a customised structure for its record, or the labour-intensive scrutiny of research psychiatry, 'attempted suicide' is exceptionally difficult to pin down. Specialised research projects begin to record it during the early 1960s. W. Malcolm Millar, George Innes and Geoffrey Sharp design a research project in order 'to make a social and psychiatric record of all "new" patients appearing for psychiatric consultation from the North-East of Scotland'[210] within the scope of the study, which is 'Hospital and Outpatient Clinics'.[211] This record form contains the following question about any patient referred to a psychiatrist: '[h]as a suicidal attempt formed any part of the present illness? Yes/No'. This is not in the diagnostics section, it is much more of a stand-alone question, but it shows the potential for 'attempted suicide' to be recorded as an object on its own. Peter Sainsbury and Jacqueline Grad report their comparative study evaluating psychiatric outpatient service in Chichester and Salisbury. Their aim is to shed some light upon disposal – principally why some patients can be treated at home and why some are admitted to mental hospitals as inpatients. They prepare a clinical record sheet for psychiatrists to record reasons for deciding upon a certain disposal option. Next to 'previous mental illness' there appears the phrase '(N.B., Suicide Attempt)'.[212] Whilst this is rather ambiguous it can be argued that its principal purpose is to remind psychiatrists that a 'suicide attempt' is to be considered as part of a 'mental illness' (even perhaps a trivial one, apt to be dismissed as a gesture). Through the use of this questionnaire, this is exactly what is achieved. However, in these two examples it requires a special record sheet and a psychiatric research project behind the recording. It becomes clearer why the Ministry-backed crossover is insufficient on its own.

The final intervention proposed at the Ministry of Health regarding this statistical follow-up is a study of 'attempted suicide' at A&E by Dr. John Brothwood, a Medical Officer. The failure of this proposal, even after the central exhortation to referral, demonstrates the difficulty of obtaining sufficient scrutiny at A&E to produce a 'cry for help'. Brothwood's proposed study involves distributing a form to casualty departments, in order to ascertain the methods and motivations behind attempted suicides. Several objections are raised about the definition of attempted suicide (by Eileen Brooke). Equally damaging questions about the practicability of obtaining the information are raised by a Dr. Otley: '[m]any of the questions… would be unanswerable or answerable on very scanty information "at the time of consultation"' by the

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[210] W.M. Millar, G. Innes, and G.A. Sharp, "Hospital and Outpatient Clinics: The Design of a Reporting System and the Difficulties to Be Expected in the Execution" (paper presented at the The burden on the community: the epidemiology of mental illness: a symposium, 1962), p.2.
[211] Ibid., p.3.
[212] P. Sainsbury and J. Grad, "Evaluation of Treatment and Services" (paper presented at the The burden on the community: the epidemiology of mental illness: a symposium, 1962), appendix I, unnumbered page.

Medical Officer in Casualty. Otley claims that 'in attempting to classify "apparent precipitating causes" it might be possible to work out a different method, involving getting information from those with *background knowledge* of the patient, (G.P., M.W.O. [Mental Welfare Officer], family when not under stress etc.) at a later stage.'[213] Schemes at the casualty department thus need special methods of investigation, channels of referral and professionals ready to undertake the heavy burden of investigation required to assess the 'intent' and fabricate a credible social field around a potential case of 'attempted suicide'. Brothwood gives up on his project slightly bitterly, saying that since the scheme was proposed, 'many additional papers have appeared in the medical press, which rendered the proposed scheme superfluous.'[214] However, the scheme fails to gain approval because the casualty department is *unsuited to the project*, allowing only 'scanty information', and the complex definitional problems that circle around intent – and might enable the intent to become communication – require those with 'background' and inescapably *social* knowledge.

The limitations of casualty differ from those in some observation wards, where treatment and follow-up are more established. However, the casualty department and the HM that seeks to intervene upon it still attempt to negotiate the enduring boundary line between psychiatric and general medicine, to reconstitute it in different contexts, through different practices, in different institutions, and this negotiation draws out 'attempted suicide'. The inescapably social, communicative 'attempted suicide' needs more than just referral to and liaison with a psychiatrist. It needs consistent psychiatric scrutiny, and more of an institutional basis which the memorandum cannot provide. The efforts of MH(61)94 at securing nationwide rates of 75% referral *do* have an effect, prompting and solidifying channels of communication and scrutiny between accident departments and psychiatric expertise. However, a lack of extra resources and the 'sorting' role of the casualty department within the NHS undercuts high-intensity psychiatric scrutiny at that site.

Finally it should be noted that the hospital memorandum and follow-up is not the only change in practice prompted by the formal change in the law. Metropolitan Police Orders are altered when it is no longer available to the police to charge a person with the offence of 'attempted suicide'. At first, draft orders include the number for the Salvation Army and the Catholic Prisoners' Aid Society as places where 'attempted suicides' might be referred. However, in April 1962 the Home Office suggests that the latter is unsuitable as no crime will have been committed, so 'attempted suicides' are not 'prisoners'; the name of the Samaritans is put

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[213] Note for Tooth from Otley dated 18.12.1964 in 'Attempted Suicide – Research Proposed by Department' , TNA: PRO: MH 150/221.
[214] Note from Brothwood to Perry dated 17.05.1965 , TNA: PRO: MH 150/221.

forward. The City of London Police forwards to the Metropolitan Police a report by Inspector A. Smith from April 1960, who had been asked to investigate the Samaritans by (City of London) Assistant Commissioner J.W. Goyder. Goyder's interest is piqued by television programme on the subject.

Smith assures Goyder that the idea of the Samaritans being 'some form of stunt can be ruled out entirely. Though having no official recognition its standing is very high indeed in City circles and beyond.' He adds that '[t]he motive appears simple enough – a genuine feeling of compassion for a fellow man in distress.'[215] After the law is changed the Metropolitan Police write to Chad Varah directly to ask his permission for the inclusion of the Samaritans' number. Varah agrees, noting that the Samaritans are 'most anxious that the Metropolitan Police should act in the same way as the City of London Police' and thus refer 'any potential or attempted suicide'.[216] The change in the law opens up another avenue for the phenomenon to become more publicised and entrenched as well as ministered to in new ways, on the basis that 'attempted suicides' are in 'distress'.

Concluding thoughts

There is a strong link between the Mental Health Act 1959 and the Suicide Act 1961. Both are implicated in a process through which different therapeutic regimes are integrated at general hospitals. This makes possible a consistent articulation of a highly psychological 'attempted suicide' with complex intent. Both involve the removal or significant retraction of the law around the field of mental disorder (with suicidal behaviour securely, though not inevitably, entrenched as part of this field). This enables a more fluid interaction between mental and general medicine, altering the kinds of clinical objects likely to emerge. The Suicide Act, in removing the legal sanctions around 'attempted suicide' does not necessarily change practices very much in one (empirical) sense; people are not being convicted very much during the 1950s. However, reform arguments have a resonant connection with ambiguous suicidal intent, and decriminalisation alters the terms of the debate through which 'attempted suicide' is conceptualised, prompting formal intervention by the Ministry of Health. It also enables the Metropolitan Police to recommend broad referral to the Samaritans, illustrating the varied concerns that emerge around 'attempted suicide' in the post-War era.

Because of the high level of psychiatric scrutiny required to produce complex, communicative intent around a presenting physical injury, HM(61)91 does not enable a huge number of studies by itself. The lack of extra resources is significant, but perhaps even more significant is

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[215] Letter from A. Smith to Assistant Commissioner dated 27.04.1960 , TNA: PRO: MEPO 2/10121.
[216] Letter from Chad Varah to Commander Townsend dated 14.05.1962 , TNA: PRO: MEPO 2/10121.

the vastly increased *potential* for the object to flourish in a number of different sites, if increased resources become available. This is another important step for the progress of a clinical object from an observation ward curiosity to one inscribed in a nationally consistent manner. The epidemic – and the broad, homogenising administrative machinery required for a multi-site epidemic – emerges through wider integration promoted through a double retraction of legal machinery in the area of mental health.

As the potential for this clinical object becomes more and more widespread and more visible, the behaviour potentially becomes more and more *available*. Ian Hacking observes that:

> '[c]ynics about one thing or another… say the epidemics are made by copycats. But even if there was a lot of copying, there is also a logical aspect to "epidemics" of this type. In each case... new possibilities for action, actions under new descriptions, come into being or become current... to use one popular phrasing, a culturally sanctioned way of expressing distress.'[217]

The idea of 'distress', used here as some sort of basic anchoring category by Hacking, also has a history. In the next chapter the growing resonance of terms such as 'stress' and 'distress' is analysed and placed into context. As we have seen, 'distress' is used in an offhand, general manner to unify and cohere the clientele of the Samaritans into an explicable group. However, psychological medicine increasingly turns to these fecund concepts to anchor and explain the prevalence and aetiology of mental disorder, and 'attempted suicide' is central in this development.

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[217] Hacking, *Rewriting*, p.236.

Chapter 4: Self-poisoning, stress and social work: projections and developments from mixed therapeutics (1961-1966)

Thus far, the phenomenon of 'attempted suicide' has been seen as produced through increased traffic between the separate therapeutic approaches of psychological and general medicine. The intensity of psychiatric scrutiny necessary to transform a presenting physical injury into a psychosocial disturbance across this divide (variously constituted in A&E and mental observation wards) has been frequently remarked upon. This chapter shows how 'attempted suicide', reframed as 'self-poisoning', is developed beyond such a hospital-based shift. With the strong academic and research base provided by Medical Research Council (MRC) funding in the work of Neil Kessel and others at Edinburgh's Royal Infirmary, the phenomenon is reliably and credibly projected into domestic space, unified by a concept of 'distress' and becomes fully established as an epidemic phenomenon. This development of 'self-poisoning' is further contextualised as part of a much wider turn to concepts of 'stress', 'distress' and 'coping' (see introduction), with increasing use of social work (see chapter two) in post-war mental health. These developments allow mental disorder to be reconceptualised as an interpersonal, fundamentally social phenomenon. Key in 'self-poisoning' are the changing practices of psychiatric social workers, who do not simply *project* this object into the home, but root it in 'the social' through *access to the home.* Once 'self-poisoning' is established in domestic social space, this space becomes productive of 'self-poisoning'. This still relies upon transformations under the mixed therapeutic regimes of 'Ward 3', but brings with it gendered dynamics of domesticity and emotionality.

In January 1959, Denis Hill[1] gives a talk to the MRC assessing their psychiatric research policy, and suggests that two psychiatric research units be established, one in psychiatric genetics under Eliot Slater, the other in psychiatric epidemiology under George Morrison Carstairs.[2] Carstairs' unit becomes central in the production of 'attempted suicide' during the 1960s. This Unit for Research on the Epidemiology of Psychiatric Illness (especially the work of Assistant Director Neil Kessel) is a key focus of this chapter, because of the high level of psychological research resources that it focuses upon 'attempted suicide', with extensive development of the potential provided by institutionally mixed therapeutics.

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[1] Hill studies neurology under Russell Brain before the Second World War, succeeds Aubrey Lewis in the Chair at the IoP in 1966, and was knighted in the same year. He is perhaps best remembered for his 'outstanding contributions to the new procedures introduced in the 1978 Medical Act about methods of handling sick doctors.' J.N.W., "Sir Denis Hill: Obituary," *British Medical Journal* 284(1982): p.1481.

[2] J.D.N. Hill, 'Review of Policy on Psychiatric Research – Summary prepared by Dr. Denis Hill of the proposals made in his talk to Council on the 16th January, 1959' , TNA: PRO: FD 9/91. See also 'Extract from Council Minutes for Meeting of 16th January 1959' , TNA: PRO: FD 7/1043.

Carstairs trains in psychological and physical medicine between 1935 and 1941 at the University of Edinburgh and serves in the Medical Service of the RAF (1942-1946). He joins the Maudsley in 1953, becoming attached to Aubrey Lewis' MRC Unit for Social Psychiatry at the IoP in February 1954.[3] He achieves brief nationwide fame following the statement in his Reith lectures that 'sexual experience, with precautions against conception, is becoming a sensible preliminary to marriage'.[4] The outrage at this supposed sanctioning of 'immorality' leads Carstairs to produce an appendix to the published version of his lectures, clarifying his position, but he expected the passage to generate controversy.[5] He is invited to be Vice-Chancellor of the University of York in 1973, but this has been described as 'uncongenial'[6] and even 'something akin to a disaster',[7] due in large part to the student protests at that time.

The start of the unit's life in the late 1950s life is chaotic. It is initially sited in London at University College Hospital, but when Alexander Kennedy, Professor of Psychological Medicine at Edinburgh dies, Carstairs asks if he can take his unit with him if he is awarded the Chair, a request which is granted.[8] The unit is moved up on the first of April 1961 with Carstairs as 'Honorary Director', and Neil Kessel as 'Assistant Director'. The key issue for the MRC in this transfer is that Carstairs' ability to direct the unit in a research-based way becomes reduced.[9] His heavy clinical and academic (as opposed to research) commitments are a recurrent theme in MRC reports on the unit's progress.[10] It falls to Neil Kessel to provide the unit's research base.

William Ivor Neil Kessel is awarded distinction in his Diploma in Psychological Medicine by Aubrey Lewis and works with Michael Shepherd in the GP Research Unit at the Institute of Psychiatry, where he delineates the concept of 'conspicuous psychiatric morbidity' –

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[3] 'George Morrison Carstairs, Curriculum Vitae' , TNA: PRO: FD 7/1043.

[4] G.M. Carstairs, *This Island Now* (Harmondsworth: Penguin, 1963), p.105.

[5] Indeed, another characteristic show of irreverence has him barred from a visit to a nuclear submarine, having included 'Aldermaston marching' under the 'hobbies' section of his *Who's Who* entry. N.K., "G.M. Carstairs," *BMJ* 302(1991): p.1202.

[6] Ibid.

[7] H.R. Rollin, "Carstairs, George Morrisson (1916-1991)," in *Oxford Dictionary of National Biography* (London: O.U.P., 2004).

[8] Joan Faulkner notes that 'Dr Carstairs is of course an Edinburgh graduate and has always wished to return to his old school.' J. Faulkner, 'Minute for file' dated 21.06.1960 in file FD 12/407. Faulkner is a 'rising administrative star' of the MRC in the 1940s, first woman to hold a senior MRC position, and married to epidemiologist Richard Doll from 1949 until her death in 2001 R. Peto and V. Beral, "'Doll, Sir (William) Richard Shaboe (1912-2005)'," in *Oxford Dictionary of National Biography* (London: O.U.P., 2009).

[9] Faulkner, 'Report / Minute for File' dated 21.06.1960 , TNA: PRO: FD 12/407.

[10] W. Malcolm Millar comments in a letter to the MRC in 1970: 'It is clear that Professor Carstairs cannot devote the time to his unit that he would have preferred'. Letter from W. Malcolm Millar to Katherine Levy dated 03.07.1970 , TNA: PRO: FD 12/412. See also Tait, "Norman Kreitman in Conversation with David Tait," p.298.

psychological disorder known to a patient's GP.[11] He conducts studies on neuroses in general practice[12] and alcoholism. This latter interest includes the Pelican Original *Alcoholism* (1965) with Henry Walton (commissioned by Carstairs)[13] and 'Suicide in Alcoholics' (1961).[14] Kessel's work in Edinburgh is overwhelmingly based at Ward 3. He becomes Professor of Psychiatry at Manchester in 1965, where he remains for the rest of his career, assisting in the creation of a detoxification service for alcoholics, and becomes the Dean of the Medical School and then Postgraduate Dean.[15]

Before the unit's transfer to Edinburgh, Kessel is not especially interested in 'attempted suicide', as demonstrated by his pre-Edinburgh publications; afterwards, in Manchester (from 1965), he focuses upon teaching and administration, also acting as government advisor on alcoholism (for the Department of Health and Social Security – the successor to the Ministry of Health from 1967).[16] However, almost all of Kessel's work in Edinburgh concerns 'attempted suicide', something about which he feels strongly enough to propose a terminological shift: calling it 'self-poisoning'; indeed, he devotes his Milroy Lectures on public health to the subject, which take the term as their title.[17] This interest can be predominantly attributed to the fact that Kessel becomes attached to 'Ward 3' at the Royal Infirmary of Edinburgh (RIE), overlapping with J.K. Slater, psychiatric registrar and physician-in-charge of this ward (as he is when Batchelor produces work there). The position of the ward between two therapeutic regimes enables certain types of physical injury to become transformed by consistent psychiatric scrutiny, most clearly shown in Kessel's previously quoted 1965 comments that '[t]here are auspicious circumstances for studying the subject in Edinburgh. For many decades the Royal Infirmary has had an 'incidental delirium' ward for patients who required *overlapping general medical and psychiatric care*.'[18] All the Edinburgh work on 'self-poisoning' is based at this specific ward, and with the return of intense research scrutiny and national attention post-Suicide Act, the object flourishes.

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[11] N. Kessel, "Psychiatric Morbidity in a London General Practice," *British Journal of Preventive & Social Medicine* 14(1960).

[12] N. Kessel and M. Shepherd, "Neurosis in Hospital and General Practice," *Journal of Mental Science* 108(1962).

[13] N. Kessel and H.J. Walton, *Alcoholism* (Harmondsworth: Penguin, 1965).

[14] Co-written with visiting U.S. Public Health Fellow Gerald Grossman. Kessel and Grossman, "Suicide in Alcoholics."

[15] B. Deakin et al., "William Ivor Neil Kessel," *Psychiatric Bulletin* 28(2004): p.309.

[16] Ibid.

[17] Kessel, "Self-Poisoning (2)."; ———, "Self-Poisoning (1)." Annual lectures on state medicine and public hygiene founded by Edinburgh physician Dr. Gavin Milroy in the nineteenth century.

[18] Kessel, "Self-Poisoning (1)," p.1265. Emphasis added.

Institutional Background

The institution of Ward 3 is, by the early 1960s explicitly associated with the phenomenon of 'self-poisoning'. It is seen to deliver a more or less complete sample for Edinburgh. Batchelor and Napier claim in the early 1950s that 'the large majority of all suicidal attempts occurring in the city of Edinburgh are admitted to this hospital',[19] a claim which runs through almost all of their work.[20]   Kessel's studies similarly argue that 'we observed more than 90% of all [attempted suicide] patients arriving at any hospital in Edinburgh.'[21] This is repeated in the 1964 MRC progress report: '[u]nique opportunities... for the study of attempted suicide were found to exist in Edinburgh because an acute ward of the Royal Infirmary, now the Regional Poisoning Treatment Centre, received over 90 per cent of all cases in the City that required hospitalisation.'[22] Kessel's work contains abundant repetition of this central plank in his production of 'Edinburgh self-poisoning'.[23] He is not arguing that the sample is 'representative' of Edinburgh, more fundamentally he claims that '[t]he case material is varied because it was complete.'[24] This is expressed on a city-wide scale, '[t]he great majority of all poisoned people from the city and near by are sent to it if they require admission'.[25] It is also registered on an inter- as well as intra-hospital level, '[i]f they first arrive at another hospital it is common for them to be transferred, but the great majority of patients are brought direct to the Infirmary, where it is the practice in the out-patient or casualty department to send to the ward all patients who have taken an overdose'.[26] It is also referred to more generally, that '[t]he emergency procedure for dealing with cases of attempted suicide in Edinburgh is widely known, simple to operate and rapid in its execution. It is invoked, on average, five or six times a week to admit a patient to ward 3 of the Royal Infirmary'.[27]

Thus, practical arrangements – 'it is the practice', 'emergency procedure' and 'customary procedure' – allow the clinicians on a single hospital ward in the RIE to construct a city-wide phenomenon. The practices are highlighted in order to undercut one of the 'disadvantage[s] of

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[19] Batchelor and Napier, "Broken Homes," p.101. The claim is repeated almost word for word in Batchelor, "Alcoholism," p.453.

[20] For example: '[t]he large majority of all persons attempting to commit suicide in the city of Edinburgh are admitted to this hospital, and it is likely that the sample is as representative of an urban population as it is possible to obtain.' Batchelor and Napier, "Sequelae," p.261.

[21] N. Kessel and W. McCulloch, "Repeated Acts of Self-Poisoning and Self-Injury," *Proceedings of the Royal Society of Medicine* 59, no.2 (1966): p.89. referring to N. Kessel et al., "Hospital Management of Attempted Suicide in Edinburgh," *Scottish Medical Journal* 9(1964).

[22] Carstairs [?] 'Progress Report 1960-64' p.5 , TNA: PRO: FD 12/408.

[23] The percentage figure remains the same from another paper which claimed that it was '[t]he customary procedure for dealing with patients who have attempted suicide in Edinburgh… to admit them to Ward 3 of the Royal Infirmary'. Kessel et al., "Hospital Management," p.333.

[24] Kessel, "Self-Poisoning (1)," p.1265.

[25] N. Kessel, W. McCulloch, and E. Simpson, "Psychiatric Service in a Centre for the Treatment of Poisoning," *British Medical Journal* 2, no.5363 (1963): p.985.

[26] Kessel, "Self-Poisoning (1)," p.1265.

[27] N. Kessel and E.M. Lee, "Attempted Suicide in Edinburgh," *Scottish Medical Journal* 7(1962): p.130.

the sample method [where] to draw conclusions of any interest, one has to argue beyond one's facts'.[28] These 'facts' are powerfully cast as complete, marking out Ward 3 as an exceptionally influential site of knowledge around the phenomenon of 'attempted suicide'. Kessel and Lee cautiously ask in 1962 'whether it is the fashion in Edinburgh to manifest disturbance by attempting suicide or whether it is merely the fashion to admit a large proportion of the cases that occur.'[29] The opposite argument is pursued by another Edinburgh physician, Henry Matthew, who runs the Scottish Poisons Information Bureau from Ward 3 between 1965 and 1974. He claims with Alexander Lawson in 1967, that their 'statistics may be regarded as representative of the British population in general as there is no reason to suspect that Edinburgh people behave differently.'[30] Similarly, Norman Kreitman in 1977 argues that 'it is reasonable to infer that the size and nature of the problem of parasuicide in Edinburgh are analogous to those of other large urban populations in Britain.'[31] Practical and institutional arrangements feed into a uniquely authoritative production of this phenomenon, under the label 'self-poisoning'.

Sclare and Hamilton, Glasgow (1963)

The wider situation in Scotland is also noteworthy. It is brought up a number of times during reform campaigns for the suicide law in England and Wales that suicide is not a crime in Scotland.[32] When the law is changed, this does not apply to Scotland, and therefore neither does the hospital memorandum HM(61)94. It is notable that despite a 'standing rule' for referral that is much older than the memorandum, there are very few studies of 'attempted suicide' in Scotland until the impetus and publicity of the 1959 and 1961 Acts.[33] One study presumably prompted by the legal shifts is the effort of A. Balfour Sclare and C.M. Hamilton in Glasgow. It illustrates the difference between a strong therapeutically mixed institution with established and consistent referral, and minor research arrangements. It is not that Sclare and Hamilton's study is inadequate to produce the phenomenon, but its efforts are dwarfed by the institutional and research potentials at Ward 3.

They note that although '[a]ttempted suicide has been described as the prime emergency of general practice', they, in contrast 'have certainly found attempted suicide to be a frequent

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[28] Slater and Woodside, *Patterns of Marriage*, p.15.

[29] Kessel and Lee, "Attempted Suicide in Edinburgh," p.134.

[30] Matthew and Lawson, *Common Acute Poisonings*, p.2.

[31] Kreitman, ed. *Parasuicide*, pp.9-11.

[32] D. Odlum, "Suicide as a Crime," *British Medical Journal* 1, no.5070 (1958); "Attempted Suicide: Changes in English Law Wanted," *British Medical Journal* 1, no.5081 (1958).

[33] In fact, Scotland has its own Mental Health (Scotland) Act (1960), but these are treated as almost identical by some researchers. See e.g. M. Woodside, "Are Observation Wards Obsolete? A Review of One Year's Experience in an Acute Male Psychiatric Admission Unit," *British Journal of Psychiatry* 114, no.513 (1968): p.1013. In any case, the point is about *publicity* and *visibility*, something much more relevant to the 1959 Act.

reason for the referral of patients to the psychiatric department of a general hospital', the Department of Psychological Medicine at the Eastern District Hospital, Glasgow. Indeed, '[o]f the 180 patients [in their series] 156 were referred from Glasgow Royal Infirmary and associated hospitals, 1 from an outlying hospital' with only '21 by general practitioners'.[34] As a result of this psychological investigation, 'marital and romance difficulties accounted for 37.2 per cent of the total cases.' Second in the list is '[f]amily relationship problem', accounting for 15%, meaning that over half are romantic, marital or familial problems.[35] They claim that '[i]n many instances of marital discord, the self-assault occurred as a final act of exasperated abdication from what the patient regarded as an intolerable situation'.[36] They do not see the act as a self-conscious 'appeal', invoking the metaphor of the computer to explain the behaviour:

> '[i]t is unsatisfactory to regard this large group as being insincere or frivolous in their behaviour… this question may be dealt with in terms of communication theory… an "information overload" an overload of unbearable stimuli to which the self-injury represented a final attempt at adaptation. Communications engineers equip their computers with automatic fuses which protect their mechanical brains from excessive stimulation. It would seem that some human beings, lacking such built-in fuses, find a substitute in self-assault.'[37]

This is a present-centred, social, frustration reaction. Having been referred to a department of psychological medicine, the social environment around the patient becomes increasingly relevant: '"attempted suicide" is certainly not a disease *sui generis*; nor is it even a syndrome in its own right. It is rather a behavioural manifestation or symptom, common to a wide variety of psychological and environmental problems.'[38] Such analysis casts 'attempted suicide' as a 'response to complex and overwhelming situations.'[39] 'Attempted suicide' is a symptom, making the disease a 'social situation'. They do report that a 'follow-up investigation 6-12 months after the self-damage is now being carried out with the aid of a social worker'[40] although it is unclear whether this is published. An established department of psychological medicine helps to bridge the therapeutic divide, and situate physical injury as a response to a social situation. However, unlike Edinburgh, this study has no claim on the 'complete' problem,

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[34] A.B. Sclare and C.M. Hamilton, "Attempted Suicide in Glasgow," *British Journal of Psychiatry* 109(1963): p.609. Again, GPs are dealt with in chapter five.
[35] Ibid.: p.612.
[36] Ibid.
[37] Ibid.: p.614.
[38] Ibid.: p.613.
[39] Ibid.: p.614.
[40] Ibid.: p.609.

and does not appear to have an institution like Ward 3 to bolster its claims. It also does not have a large number of full-time research psychiatrists and PSWs based at the hospital to expend the necessary effort on these therapeutic negotiations. Despite the Scotland-wide standing rule,[41] and historic lack of legal constraint, this is just one more emergence of a 'growing' problem across Britain.

Kessel's 'self-poisoning': similarities and modifications

Kessel's 'self-poisoning' is different in three main ways from Stengel and Cook and Batchelor and Napier. The self-conscious nature of the appeal is the strongest and simplest notion of intent yet seen, and the archetypal behaviours and gender stereotypes are explicitly discussed. Furthermore, Kessel's 'self-poisoning' is fundamentally rooted in an amorphous category of 'distress'. This emotional state is common to all 'self-poisoning' episodes, through which it becomes a distinct, coherent clinical object. Thus in all three ways, Kessel's 'self-poisoning' is more definitely, more precisely and more securely established – the 'intent' is self-consciously to 'appeal', the stereotypes of 'young women' and 'overdose' are explicit, and interpersonal, present-centred 'stress' and 'distress' hold the object together at a deep conceptual level. Having outlined differences, it is important to note the familiar quality of this object; much remains the same under this new term.

Similarities: lethality, intent and the social setting

Much of the intense, involved scrutiny again focuses upon issues of 'lethality' and 'intent'. In 1966 Kessel produces an 'Index of Endangering Life' (figure one).[42] It shows again how assessments of the 'social setting' complicate ideas of 'intent' and how this ambiguous mix is elevated over physical 'lethality' in the significance of 'self-poisoning'. The 'estimated consequences of what the patient took' labels the rows, and the 'action by patient to avoid or ensure discovery' labels the columns. This diagram performs (and obscures) intellectual work, another way of positioning 'self-poisoning' in an 'interpersonal' social space.

Figure one

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[41] See chapter two.
[42] Kessel, "Respectability," p.33.

INDEX OF ENDANGERING LIFE.

		ACTION BY PATIENT TO AVOID OR ENSURE DISCOVERY.		
		AVOID DISCOVERY	NEUTRAL	ENSURE DISCOVERY
ESTIMATED UNTREATED CONSEQUENCES OF WHAT THE PATIENT TOOK.	FATAL.			
	CRITICAL.			
	UNLIKELY TO DIE.			
	SURE SURVIVAL.			

PREDICTABLE OUTCOME

- DEATH.
- DEATH PROBABLE.
- DEATH UNLIKELY.
- CERTAIN TO SURVIVE.

INDEX CATEGORIES.

It achieves this through its asymmetry, through the extra white on the third column. Reading off the 'index', a 'critical' dose of drugs when discovery is ensured corresponds to 'certain survival'. Similarly surprising is that a 'fatal' dose of drugs when sure to be discovered means that 'death is unlikely'. The almost totally white column constitutes an argument for the primacy of 'discovery', of *communicative engagement with social context* over and above the *physical effects* of the overdose. As noted previously (especially in Stengel's work), key to this wider object of 'attempted suicide' is that the physical severity of the attempt is argued to be an unreliable guide to suicidal intent. This diagram makes the point visually. An overdose might be considered potentially *physically* fatal, but if performed as part of 'an appeal' (here flattened into 'discovery' precautions), is not fatal at all. This is an argument, not just a slightly gratuitous formal visualization or space-filler (although it may be both of those as well). It shows the continuing negotiation between assessments of physical damage or lethality, and assessments of the social setting: the latter is again considered more significant.

This concern with lethality is also an intervention in a debate between therapeutic regimes (as it is in Stengel, Cook and Kreeger[43]). Kessel, McCulloch and Simpson make it very explicit in 1963 that physical danger to life and psychiatric pathology are to be assessed separately:

> 'no simple relationship exists between the degree of danger to life and the seriousness of any psychological disorder present. Many people who have been deeply unconscious we allow to go home after physical recovery because they require only a minimum of psychiatric supervision afterwards; on the other hand,

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[43] They argue 'it can be stated that fairly frequently there was a marked discrepancy between the degree of self-injury and the severity of the mental disorder'. Stengel, Cook, and Kreeger, *Attempted Suicide*, p.47.

a sixth of the patients who had not risked their life at all needed admission to a psychiatric hospital, and many more needed extensive out-patient care.'[44]

The complexity of the relationship between 'danger to life' and a 'psychological disorder' does not herald any significant overlap between concepts of 'psychological' and 'somatic' damage/significance. They continue: '[a]lthough on the whole… the more [physically] "serious" cases are more likely to call for active psychological intervention… it certainly is not right that mildness of method indicates lack of severity of psychological illness.'[45] A year later Kessel and different collaborators are even more forthright: '[w]e have described elsewhere (Kessel *et al.*, 1963) the fallacies and, indeed, dangers inherent in using this yardstick of physical damage to judge whether the patient needs psychological treatment'.[46] It is not enough to deal with 'just' the 'physical' and send people on their way. This is precisely because there exists another, separate order of problems. The clinical object exists between therapeutic regimes, but (somatic) lethality is downplayed by a focus upon an intent that is inextricably linked to 'the social'. The 'cry for help' is a tactical intervention between the therapeutic regimes where the significance of the act is determined not by its somatic sequelae but its psychosocial context.

Differences and modifications: self-consciousness, stereotypes and 'stress'

In 1965 Kessel gives the Milroy Lectures at the Royal College of Physicians, entitled 'Self-poisoning'. These two articles are key in further publicising the terminological debate around attempted suicide. Rather than accept Stengel and Cook's increasingly established modification of the term, Kessel finds 'attempted suicide', 'both clinically inappropriate and misleading',[47] advancing 'self-poisoning' because he claims that 'it describes the phenomenon without interpreting it along a single pathway'.[48] However, Kessel is opening up and closing down various possibilities; it is somewhat disingenuous to accept this labelling as 'without interpreting'. His terminological offering is intended to sidestep issues of intention ('interpreting' here indicates assessments of *intent*), but collapses all possible behaviours into one archetype.

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[44] Kessel, McCulloch, and Simpson, "Psychiatric Service," p.987.

[45] Ibid.

[46] Kessel et al., "Hospital Management," p.334. McCulloch and Philip, argue that 'persons unskilled in psychiatry tend to equate the severity of the physical state with the severity of the underlying problem. There is no such easy equation'. McCulloch and Philip, *Suicidal Behaviour*, p.31.

[47] Kessel, "Self-Poisoning (2)," p.1339.

[48] ———, "Respectability," p.35.

One of Kessel's less orthodox practices in the production of 'self-poisoning' is mentioned in his obituary,[49] and he describes it fully in these lectures:

> 'We sent a girl (Fig. 5) sobbing into six chemist shops within a mile of each other in Edinburgh. In each she said: "May I buy 200 aspirins, please?"… Nowhere was she refused, whether she was served by an assistant or by the manager. Only once was any concern expressed: "Two hundred? Are you all right? You ought to go and have a cup of tea"… a distraught-looking girl, 200 aspirins asked for, curiosity and interest, but no hesitation about the sale. This is irresponsible.'[50]

Figure two

FIG. 5.—This distraught-looking girl was sold large quantities of aspirin.

This is a rich historical scenario, a psychiatrist carrying out a social experiment. A 'sobbing girl' is presumed typical, and buying a 'large quantity' of aspirin in a state of distress is self-evidently a 'self-poisoning' or 'attempted suicide' risk, to the extent that it is 'irresponsible' not to intervene. The content is even more complicated because this 'performance' by an actor hired for the purpose has an uneasy relationship to the performative aspects of the clinical object he is publicising.

Kessel concedes that 'it has become increasingly difficult to define the act,'[51] but nevertheless describes the 'real thing' or clinical object thus: 'attempted suicide has been defined as deliberate self-poisoning or deliberate self-injury *mimicking* suicide'.[52] He continues: 'the *simulation* of death, consciously or not, the hint of suicide, heightened its effectiveness. But

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[49] Deakin et al., "William Ivor Neil Kessel," p.309.
[50] Kessel, "Self-Poisoning (2)," p.1338.
[51] Kessel, McCulloch, and Simpson, "Psychiatric Service," p.987.
[52] Kessel et al., "Hospital Management," p.333. Emphasis added.

the act was not attempted suicide. Doctors do not have to be deceived by their *simulation*; the *drama* was enacted for their own circle only.'[53] The self-evident poisoning risk of this self-consciously scripted and acted performance of a 'distraught-looking girl' thus performs what is already seen as a 'performance' and dramatizes the 'dramatic'. Such descriptive terms expose a simplification of intent: this is not Batchelor and Napier's childhood emotional trauma surfacing, nor Stengel and Cook's unconscious, ambiguous 'ordeal'. This is performance, deception and drama. The object is still unarguably social, but now very much self-consciously so. This is clearest in one of his last publications on the subject – 'The respectability of self-poisoning and the fashion for survival' (1966). He claims that 'it is common knowledge that you can take a lot of pills, lose consciousness and later return to it none the worse for the experience.'[54]

Aside from this development and stabilisation of intent, the three pillars of Kessel's 'self-poisoning' are his behavioural archetype, his assertion that 'distress' is the unifying feature of this group and a more explicit account of the gendered nature of this phenomenon. All these have resonances and connections with wider trends during this period. 'Self-poisoning' is linked to anxieties about prescribing and pharmaceuticals as well as the specific context of the 'Ward for Incidental Delirium'. 'Distress' is a broad enabling category underneath the turn to the 'social' in psychiatry and medicine in this period, but is also reiterated and continually made relevant by the specific practical possibilities of PSWs. These PSWs carry significant gendered freight, articulating 'distress' as specifically 'domestic'. These three parts of 'self-poisoning' are explored in turn.

'Self-poisoning' as resonant archetypal method of 'attempted suicide'

Kessel does not totally close off other behaviours possibly covered by 'attempted suicide' ('self-cutters' or 'throat- or wrist-slashers' for example) but his terminology is exclusionary, even if those so identified are still treated at the ward.[55] This shifts inclusions and emphases – rather than just 'not interpreting' – making it 'a matter of determining *which* simplification or simplifications we will attend to and create and, as we do this, of attending to what they foreground and draw our attention to, as well as what they relegate to the background.'[56]

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[53] Kessel, "Self-Poisoning (2)," p.1339. Emphasis added.
[54] ———, "Respectability," p.30.
[55] In the early 1960s, he works under 'an operational definition that included all cases of overdosage, gassing or injury admitted to the ward, where it could be established that these were self-inflicted.' Kessel and Lee, "Attempted Suicide in Edinburgh," p.130.
[56] J. Law and A. Mol, "Complexities: An Introduction," in *Complexities: Social Studies of Knowledge Practices*, ed. J. Law and A. Mol (Durham: Duke University press, 2002), p.11. Emphasis added.

Awareness of the phenomenon of 'self-poisoning' with drugs changes within administrative structures of hospital care during the 1940s and 1950s.[57] Alex Proudfoot (toxicologist at Edinburgh's Regional Poisoning Treatment Centre from the late 1960s) relates that '[t]he first resuscitation centre dedicated to poisoned patients had been opened in Bispebjerg Hospital, Copenhagen, in 1949. In the south of England, a similar unit, the North-East Metropolitan Regional Barbiturate Unit, was set up in Oldchurch Hospital, Romford, in the 1950s.'[58] Comments made by the head of this unit, Sidney Locket, indicate that certain forms of poisoning have a potential affinity (in the eyes of some clinicians) with 'gestures': 'barbiturate poisoning is notorious in that it is not a particularly lethal variety of poisoning. Barbiturate poisoning is important because of its frequency and not because it is highly lethal.'[59] Locket does not comment further on the consequences of toxicological assessments of 'lethality' for psychological assessments of intent. However, Stengel and Cook make a connection with poisoning in general, arguing that '[c]learly, the degree of danger to life is not a reliable measure of seriousness of intent, especially with poisoning, i.e. in the majority of suicidal acts.'[60] Thus, ambiguity of *method* is transposed onto ambiguity of *intent*, and in an act of 'attempted suicide' where complicated intent is right at the core of the behaviour, this method has special resonance and visibility.[61] J.K. Slater also argues that the 'great majority' of barbiturate self-poisoners survive, 'but doubtless quite a few were histrionic and therefore not really serious attempts (this aspect is often difficult to ascertain).'[62] However, there is nothing *inherently* ambiguous about this method; such a claim falls into technological determinism. The self-consciousness of Kessel's appeal overrides any ambiguity in his aforementioned claim that 'it is common knowledge that you can take a lot of pills, lose consciousness and later return to it none the worse for the experience'.[63]

Ward 3 gradually acquires an association with poisoning *specifically* according to JK Slater's 1962 memorandum (see chapter two). When the police's 'unruly customers, "delirium tremens" and such like'[64] begin to be admitted regularly (recalling Batchelor's 1950s concern with alcoholism), the association between unruly alcoholics and possibly self-destructive poisoning is one possible reason the phenomenon might take this form at this site. However, it

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[57] Frederick Hopkins' comments on 'poisoning' are more related to 'coal gas poisoning'. Hopkins, "Attempted Suicide," pp.75-76.

[58] A. Proudfoot and L.F. Lescott, "Henry Matthew: The Father of Modern Clinical Toxicology," *Journal of the Royal College of Physicians of Edinburgh* 39(2009): p.358.

[59] S. Locket, "Barbiturate Deaths," *British Medical Journal* 2, no.5162 (1959): p.1332.

[60] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.113.

[61] A gunshot to the head – which is potentially survivable – is not considered 'communicative' in the same way in this context, precisely upon the grounds of 'lethality'.

[62] Slater 'Revaluation' p.2

[63] Kessel, "Respectability," p.30.

[64] Slater 'Revaluation' p.1

is more likely that the 'secure' function of the ward brings 'attempted suicides' to Ward 3 (even though 'attempted suicide' is not an offence in Scotland). The critical elision appears at some point during the inter-war period when 'the authorities, never slow to recognise advantages, found that Ward 3 was admirably suited to their difficulties about failed suicides and thus followed other forms of poisoning, including the accidental ones.'[65] The Ward's poisoning associations shift from 'delirium tremens' through to 'attempted suicides' as elided into poisonings, which are then broadened out to encompass accidental poisonings. This trend collapses all possible forms into one archetype. This is then emphasised, as part of the value and uniqueness of the ward: '[i]n this charge we have a splendid opportunity of observing large numbers of selected cases, for example, in the year 1959-60 there were admitted 223 cases of barbiturate poisoning'.[66] Indeed, 'it is in the main a centre where gravitate all, or mostly all, the poison cases in the area, accidental or otherwise, mostly alas, the latter.'[67]

Poisoning: national concerns and Governmental committees

A subcommittee of the Standing Medical Advisory Committee issues a report on the Treatment in Hospital of Acute Poisoning under the chairmanship of Guy's Hospital Surgeon Hedley Atkins in 1962. According to a memorandum circulated at the first meeting of this committee in 1959, it is set up on the basis that:

> '[a] certain amount of publicity is constantly being given to the dangers associated with poisons. Questions in the House of Commons recently expressed anxiety at the increase in accidental deaths due to the barbiturate group of drugs, and the Minister of Health said in reply that he would ask for attention to be paid to the need for special caution in their use.'[68]

It is notable that (as late as 1959) *accidental*, rather than suicidal poisoning is the reason for the committee's establishment. This report has specific significance for Ward 3, which is designated a Regional Poisoning Treatment Centre (RPTC) in 1962[69] in accordance with Atkins Committee recommendations[70]; it forms a 'natural locus for the establishment of a centre' according to Kreitman. The Hill Report (1968), issued by a committee chaired by Denis Hill, reiterates the earlier recommendations, that regional poisoning treatment centres should be

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[65] Ibid.
[66] Ibid. pp.1-2.
[67] Ibid. p.3.
[68] Dr. Dooley 'The Problem of Accidental Poisoning in England and Wales and Arrangements for Prevention and Treatment', TNA: PRO: MH 133/230.
[69] See 'Poisons Information Bureau 1962-1974' LHB 1/80/104.
[70] Central Health Services Council, "Report of the Sub Committee: Emergency Treatment in Hospital of Cases of Acute Poisoning." There is also a report by the Scottish Bureau.

established for the specialist treatment of acute poisoning.[71] Henry Matthew, Slater's successor as Physician-in-Charge of Ward 3, comments in 1969 that '[s]uch a centre has evolved at the Royal Infirmary of Edinburgh over the past 90 years, and during recent years it has functioned in the manner recommended in the Atkins and Hill Reports'.[72]

One of the papers circulated to the Atkins Committee in the early 1960s involves a more technical – but still important – concern: having ambulances carry the right mix of carbon dioxide and oxygen with which to treat patients poisoned with carbon monoxide. This shows how 'acute poisoning' is not necessarily associated with pills or an 'overdose', but it becomes that way, during this period. The decline of carbon monoxide (CO) or coal gas poisoning – the method with which poet Sylvia Plath ends her life in 1962 – coincides with the increasing number of British houses switched from coal gas to natural gas from the mid-1960s. Norman Kreitman writes on this subject from Edinburgh[73] as do W.H. Trethowan and Christine Hassall in Birmingham.[74] These concerns show the narrowing that takes place when switching terminology from 'self-poisoning' to 'overdosing' – there is no 'normal dose' of carbon monoxide.

The wider significance of the 'overdosing' archetype is explicable partially in terms of anxieties around prescription medication. It is in this context that Stengel (under the term 'attempted suicide') notes a preponderance of drug-based attempts over other methods at all their sites. The 'easier availability of narcotic drugs was deemed the most important factor,'[75] with 'the easier availability and consequently greater consumption of sedatives since the institution of the National Health Service' said to be behind the rise of this method in particular. Kessel argues that 'unforeseen byproduct of the National Health Service has been the ready availability of poisonous drugs… frequently prescribed with a libertarian attitude amounting almost to abandon… The result has been to radically alter the pre-existing ways of attempting suicide.'[76] In a more colourful phrase, he claims that '[s]leeping tablets, and they are mostly barbiturates, are the accepted mid-twentieth-century passport to oblivion, and doctors seem only too ready to issue the necessary visa.'[77] The importance of drugs as the archetypal method of 'attempted suicide as a cry for help' continues to rise throughout the 1960s.

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[71] Standing Medical Advisory Committee Central Health Services Council, "Hospital Treatment of Acute Poisoning. Report of the Joint Sub-Committee of the Standing Medical Advisory Committees," (London1968).

[72] H. Matthew et al., "Acute Poisoning: Organization and Work-Load of a Treatment Centre," *British Medical Journal* 3, no.5669 (1969).

[73] N. Kreitman, "The Coal Gas Story. United Kingdom Suicide Rates, 1960-71," *British Journal of Preventive & Social Medicine* 30, no.2 (1976).

[74] C. Hassall and W.H. Trethowan, "Suicide in Birmingham," *British Medical Journal* 1, no.5802 (1972).

[75] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.111.

[76] Kessel, "Attempted Suicide," p.313.

[77] ———, "Self-Poisoning (1)," p.1269.

General Practitioner C.A.H. Watts expresses the opinion in 1966 that '[t]he death of Marilyn Monroe has no doubt helped to popularize the overdose of sleeping tablets. Suggestibility and fashion, together with the fact that from 1961 attempted suicide ceased to be a felony [sic], in part account for the incredible number of attempts which occur today.'[78]

These concerns around 'overprescribing' are exemplified by Karen Dunnell and Ann Cartwright's book *Medicine Takers, Prescribers and Hoarders* (1972),[79] which is also part of the important and complicated issue of the supposedly meteoric rise of psychoactive medications in mental healthcare and the technologies of the randomised controlled trial (RCT).[80] In a non-psychiatric context, there is a huge crisis of confidence over drug safety around the 'Thalidomide disaster'. During the late 1950s and early 1960s the drug is prescribed as an anti-emetic (among other things) to help to counter the 'morning sickness' associated with the early stages of pregnancy; it is then causally associated with malformations of foetuses.[81] The committee set up to enquire into how this could have been allowed onto the market is chaired by Derrick Dunlop. 'Drugs' register on still broader levels. Russell Brain's committee on drug addiction issues reports in 1961 and 1965 on morphine, heroin and cocaine addiction.[82] There are well-publicised debates around cannabis,[83] and when the Wootton Report[84] recommends the decriminalisation of cannabis in 1969, Home Secretary James Callaghan is sufficiently moved to speak out in the House of Commons against the 'advancing tide of so-called permissiveness' in the country.[85] In the middle of all this, Kessel's narrowing of a behavioural stereotype around 'attempted suicide' passes almost unnoticed.

'Distress' as unifying and the 'social constellation'

Another of Kessel's modifications revolves around 'distress', a concept analysed in the introduction as having inescapably social overtones. He explicitly adapts Batchelor and Napier's insights on the aetiology of this phenomenon, moving away from childhood emotional trauma towards present-focussed stressful situations. This shift can partially be explained in terms of changes in the practices of the PSWs that form a vital part of Kessel's

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[78] Watts, *Depressive Disorders*, p.131. 'Attempted suicide' ceases to be a *common law misdemeanour* when 'suicide' ceases to be a felony in 1961.

[79] K. Dunnell and A. Cartwright, *Medicine Takers, Prescribers and Hoarders* (London: Routledge and Kegan Paul, 1972).

[80] E.g. C.M. Callahan and G.E. Berrios, *Reinventing Depression: A History of the Treatment of Depression in Primary Care, 1940-2004* (Oxford: O.U.P., 2005).

[81] J. Botting, "The History of Thalidomide," *Drug News & Perspectives* 15, no.9 (2002).

[82] W.R. Brain, "Drug Addiction: The Second Report of the Interdepartmental Committee," (London1965); ———, "Drug Addiction: Report of the Interdepartmental Committee," (London: Ministry of Health, 1961).

[83] E.g. M. Schofield, *The Strange Case of Pot* (Harmondsworth: Penguin, 1971).

[84] Drug Dependence Advisory Committee, "Cannabis: Report (Wootton Report)," (London1968).

[85] HC Deb 27 January 1969 vol 776 col 959. This phrase is widely quoted as 'rising tide of permissiveness' e.g. K.O. Morgan, *Callaghan: A Life* (Oxford: O.U.P., 1997), p.320.

project. Furthermore, 'distress' not only unifies 'self-poisoning', but manages the troublesome boundary between pathology and normality in social psychiatry, to the extent that pathology can be projected onto individuals in the social circle rather than the patient admitted having 'self-poisoned'. This development is also related to PSW practices, especially the influence of marriage guidance.

Kessel is not the first to use the terms 'stress' and 'distress' around this phenomenon,[86] but he is the first to *unify* it under such a concept. 'Distress' is what makes 'self-poisoners' a cohesive group. Kessel asks: '[i]s there a unifying basis to self-poisoning acts? Is there some feature that informs them all?' His answer is that '[d]istress drives people to self-poisoning acts: distress and despair, unhappiness and desperation.'[87] He quotes this particular passage in a letter to the *British Journal of Psychiatry* (*BJP*) fully thirteen years later in 1978, against Bristol's C.P. Seager whose alternative term 'propetia' (derived from the Greek for 'rashness') fails to catch on.[88] Irving Kreeger claims in 1966 'suicide is not a circumscribed entity but a method of reacting to stress which cuts across most of the formal diagnostic categories.'[89] McCulloch and Alistair Philip[90] declare in *Suicidal Behaviour* (1972) that '[w]e firmly endorse Kessel's statement that "*distress drives people to self-poisoning acts.*"'[91] 'Distress' is explicitly emphasized at the core of the behaviour.

This 'distress' functions in a similarly cohesive way to Kessel's earlier use of the term 'neurosis' where he claims that '[n]eurosis is an agreeably vague word... used here to embrace all those emotional disturbances, anxiety states, hysterical reactions, phobias, obsessions and depressions which become transmuted into illnesses by the simple process of taking them to the doctor.'[92] In a similar vein, Richard Asher claims that 'an increase in illnesses caused by stress – the huge amount of psycho-somatic illnesses found today – [does not] mean anything more than a shifting of the blame for their troubles which both doctors and patients like to place squarely on some real or imaginary source.'[93] Asher does not see the increase in psychosomatic illness as part of a growing overlap between separate therapeutic regimes, he attributes it to 'fashions in disease', just as Kessel talks of the 'fashion for survival' after 'self-poisoning'.

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[86] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.116. Woodside, "Attempted Suicides," p.411.
[87] Kessel, "Self-Poisoning (2)," p.1336.
[88] C.P. Seager, "What's in a Name? Attempted Suicide," *British Journal of Psychiatry* 132(1978): p.206; N. Kessel, "What's in a Name? Attempted Suicide," *British Journal of Psychiatry* 132(1978): p.207.
[89] I.S. Kreeger, "Initial Assessment of Suicidal Risk," *Proceedings of the Royal Society of Medicine* 59, no.2 (1966): p.92.
[90] PhD candidate at Edinburgh University and later Unit member.
[91] McCulloch and Philip, *Suicidal Behaviour*, p.31. Original emphasis.
[92] N. Kessel, "Neurosis & the N.H.S.," *The Twentieth Century* CLXXII, no.1015 (1962): p.55.
[93] R.A.J. Asher, "Fashions in Disease," *The Twentieth Century* CLXXII, no.1015 (1962): p.18.

There is a distinctively evolutionary angle to much work on stress. Because Walter Cannon and Hans Selye[94] draw their insights from animal experiments, 'stress' is conceived of as an adaptive response applicable to animals more broadly, rooted deep in the evolutionary past (otherwise animal results have no significance for humans).[95] What is interesting about the ideas of 'distress' mobilised by clinicians concerned with 'attempted suicide' is the lack of *explicitly* evolutionary explanations, or those using animal experiments and 'ethology'. Clearly, the concept of 'distress/stress' gains traction because of these influential explanatory systems. It is not denied the 'stress' described here might rely at some level on unspoken evolutionary assumptions, but to uncover and chart these is another project. As noted, Bowlby's theories of the emotional damage caused by disruptions in childhood environments is used in Batchelor and Napier's work on 'attempted suicide' coming out of Edinburgh in the early 1950s. The links to Bowlby are important in terms of evolutionary explanations because:

> '[f]rom early on in his career, Bowlby was interested in finding a biological foundation for the child's emotional needs… The mounting criticisms of the observational studies on children also probably encouraged him to look to other areas to support his views. He was thus happy to encounter the work of ethologists Konrad Lorenz and Niko Tinbergen, who postulated the existence of instincts to explain animal and human social behaviour.'[96]

Vicedo's analysis of Bowlby's encounter with the ethnography of Lorenz and Tinbergen is important because it shows that the adoption of theoretical underpinnings is often a *process*, rather than something done wholesale and at once. It shows that Bowlby gradually includes more ethological studies in his published work across the 1950s (alongside the previously noted embryological arguments), even though ethological traces can be found in his earliest work from the late 1930s.[97] Explicitly ethologically guaranteed iterations of 'stress' certainly circulate in Britain in this period, but so do much broader 'folk' associations in a resurgent social psychiatry and psychiatric epidemiology, newly underpinned by wartime and post-war morbidity surveys that participate in the inscription of 'mental distress' onto and into social

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[94] See introduction.

[95] For the explicit connection of 'attempted suicide' to stress-based 'life events' see E.S. Paykel, B.A. Prusoff, and J.K. Myers, "Suicide Attempts and Recent Life Events. A Controlled Comparison," *Archives of General Psychiatry* 32, no.3 (1975). For connections between Brown and Harris and 'self-poisoning' see Jack, *Women and Attempted Suicide*, pp.154-156.

[96] Vicedo, "Bowlby's Theory of Attachment." See chapter two.

[97] 'In his first papers he had discussed animal research about primates and considered this work relevant to explanations of human behaviour.' E.g. the appendix to E.F.M. Durbin and J. Bowlby, *Personal Aggressiveness and War* (London: Routledge & K. Paul, 1939). See Vicedo, "Bowlby's Theory of Attachment," pp.419-420, n.457.

relationships. Stengel and Cook seem rather ambivalent about Lorenz and Tinbergen, asserting in a footnote that:

> '[t]he study of certain behaviour patterns in animals, which has been called "ethology"… has resulted in discoveries of importance to human psychology and psychopathology. Certain "sign stimuli" emitted by one animal were found to elicit certain patterns of behaviour among other animals with great regularity. Where these stimuli gave rise to social behaviour patterns they were called "Social releasers". The suicidal attempt acts very much as a "social releaser". Whether the reactions it calls forth are innate or culturally determined remains to be explored.'[98]

The final sentence is important, as Stengel, Cook and Kreeger refuse to be drawn on the issue of 'innateness', which leads down the road to deep evolutionary explanations. They also claim, in a rather opaque manner that '[f]rom the biological aspect, we may regard the suicidal attempt as a catastrophic reaction to an intolerable social and emotional situation,'[99] although the precise meaning of 'biological' is unclear here. 'Ethology' references do not feature in the two editions of Stengel's the Pelican Original *Suicide and Attempted Suicide* (1964 and 1970), and the only reference to animal study and evolution downplays its importance: '[s]uicide is specifically a human problem… as far as we know, only man can will his death and kill himself… Self-destructive behaviour not associated with death is not suicide. At some stage of evolution man must have discovered that he can kill not only animals and his fellow-men but also himself'.[100] There are significant tensions here, given that Stengel is attempting to complicate the intent to die (thus 'attempted suicide' is still associated with death in Stengel's scheme). However, he looks to emphasise *communication* – of which animals presumably are capable – but is obviously more hostile to 'ethology' in the 1960s than in the late 1950s.

'Distress' here functions much more like the 'miasma of social psychiatry' detailed in the introduction, encapsulating, in the words of David Armstrong, concerns over '[s]ubjectivity, meaning, idiosyncrasy, feelings, a social nexus – themes which were to dominate certain post-war analyses of the doctor-patient relationship'.[101] Whilst Rhodri Hayward has shown that Brown and Harris' work on stress and 'life events' in 1970s Camberwell *is* underpinned by an appeal to an 'evolutionary context… a familiar ethological drama of confrontation and

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[98] Stengel, Cook, and Kreeger, *Attempted Suicide*, p.117.
[99] Ibid., p.22.
[100] E. Stengel, *Suicide and Attempted Suicide* (Harmondsworth: Penguin Books 1964), pp.11-12. For an historical discussion of this topic see E. Ramsden and D. Wilson, "The Nature of Suicide: Science and the Self-Destructive Animal," *Endeavour* 34, no.1 (2010).
[101] Armstrong, *Political Anatomy*, p.106.

withdrawal',[102] this emphasis is not overt in late 1950s and early 1960s analyses of 'attempted suicide'. In 1992, Raymond Jack surveys the models that have been used to explain 'self-poisoning'. He argues that 'stress' has been seen as key, and shows how closely 'stress' comes to stand in for the 'social environment': 'stress is external to individuals and emanates from the social conditions which govern their everyday lives'.[103] Kessel's 'distress' gains purchase through a rhetorical, all-encompassing self-evidence, which (as argued in the introduction), is necessary for psychiatric epidemiology and social psychiatry to make sense in the post-war period. This distress, bound up in conceptions of 'the social' may be self-evident in certain contexts, but Kessel's is also rooted in practical arrangements – especially psychiatric social work – that are fundamental to its articulation.

'The Social' through Social Workers – PSWs at Edinburgh

During the early 1960s, PSWs come to occupy a prominent place in Kessel's studies of 'self-poisoning'. He works most closely with PSWs Elizabeth Lee, then J. Wallace McCulloch, continuing the collaborative focus of Batchelor and Napier, and Stengel and Cook. Joan Faulkner records in a 1962 report that Carstairs informed her that 'in Edinburgh the Medical Officer of Health was an enthusiastic exponent of home treatment for the mentally ill and had been training his Health Visitors to act as P.S.Ws. This was not true of the surrounding localities.'[104] The potential to carry out such investigations is not widespread. In fact, to have PSWs as part of a local authority service (as they would be if combining the role with Health Visiting) is exceptional. In 1951 Younghusband claims that PSWs are 'mainly employed by mental hospitals, or in psychiatric departments or child guidance clinics under regional hospital boards or teaching hospitals, or by local education authorities in child guidance centres' but only 'to a very limited extent by local health authorities in the community care of the mentally ill or defective.'[105] The broader shift, post-1959 towards 'community care' brings social work to renewed prominence. In the foreword to Munro and McCulloch's *Psychiatry for Social Workers* in 1968 it is claimed that '[p]sychiatry is showing a healthy tendency to emerge from hospital into the community and in doing so it leans much more heavily than before on the assistance of every type of social worker.'[106] When mental healthcare becomes increasingly organised

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[102] Hayward, "Sadness in Camberwell [Draft]." Brown and Harris, *Social Origins*.

[103] Jack, *Women and Attempted Suicide*, p.21.

[104] J. Faulkner 'Note on visit to the Unit for Research on the Epidemiology of Psychiatric Illness Edinburgh' 09.11.1962 dated 29.01.1963 pp.1-2, TNA: PRO: FD 12/408.

[105] Younghusband, *Supplementary Report*, p.81.

[106] J.P. Nursten 'Editor's Foreword' to A. Munro and J.W. McCulloch, *Psychiatry for Social Workers*, 2nd ed. (Oxford: Pergamon Press, 1975), p.xiii.

around outpatient departments (especially after 1959[107]) the twin practices of 'home visiting' and 'social history taking' have even more potential to fabricate a credible social space around any given case of mental disorder. There is thus a significant amount of socially-focused expertise upon which Kessel can draw.

The health visitor-PSW training scheme is still not enough for Kessel, who complains in 'Attempted Suicide in Edinburgh' (1962) that a '[s]hortage of psychiatric social workers makes it difficult to obtain additional information; when their services are available it is more often to provide after-care than to augment the history.'[108] However, a footnote acknowledges that '[t]his paper was submitted for publication in 1961. Since then there has been an increase in the allocation of psychiatric and social work time. This now permits a fuller investigation of each case.'[109] Difficulties elsewhere are hinted at by John Wing in 1963, when he describes some of the arrangements for a psychiatric research project at the MRC's Social Psychiatry Research Unit at the Maudsley: 'there will be three social workers involved. It is not usually possible to find highly qualified, trained people for this work.'[110] The relative abundance of PSWs at Edinburgh has a significant impact upon the knowledge produced about 'self-poisoning'. It broadens the spaces of investigation, from the various hospital spaces (the accident and emergency department, Ward 3, etc.) through such practices as home visits (see chapter two), and enhances the credibility of any projections into and across those spaces. These visions of domesticity and their role in stabilising this phenomenon are further analysed in the final chapter.

Kessel is explicit (to a much greater extent than Batchelor) about the PSW role in the investigations into 'self-poisoning'. In 1963 he argues that 'we need as much of the P.S.W.'s time as of the psychiatrist's' which 'reflects the importance we place upon social work both in elucidating the circumstances leading to the overdosage and in dealing with the *complicated social nexuses* and *tangled personal relationships* that beset so many of these patients.'[111] In addition, 'arrangements are made for the psychiatric social worker to interview a key informant',[112] a spouse or relative, and then, 'a clinical conference is held at which the patient is seen by the whole team; social and clinical details are put together and the disposal of the

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[107] 'Many PSWs attached to mental hospitals had been much opposed to the transfer of after-care from the hospital to the local authority, but once this had become a *fait accompli*, growing numbers of them began to move away from hospital to local authority.' Irvine, "Psychiatric Social Work," p.180.

[108] Kessel and Lee, "Attempted Suicide in Edinburgh," p.130.

[109] Ibid.: p.130n.

[110] J.K. Wing, "Survey Methods and the Psychiatrist," in *Methods of Psychiatric Research*, ed. P. Sainsbury and N. Kreitman (London: O.U.P., 1963), p.118.

[111] Kessel, McCulloch, and Simpson, "Psychiatric Service," p.987. Emphases added.

[112] Ibid.: p.985.

patient is arranged.'[113]   These are the practices upon which an interpersonal, 'social constellation' is built, explicitly acknowledged.

J. Wallace McCulloch is the senior social worker at the unit in Edinburgh from 1961 until 1968, and he is already at the Royal Infirmary when the unit arrives in 1961. He 'transferred to the Unit staff soon after [the unit arrives]'.[114] Faulkner's 1962 report shows that 'Mr. McCulloch, the Senior Psychiatric Social Worker... spends most of his time with Dr. Kessel in the Royal Infirmary'[115] and that 'Dr. Kessel's major study recently has been that of attempted suicides admitted to Ward 3 of the Royal Infirmary.'[116] It is McCulloch who appears to miss Kessel the most when the latter leaves for Manchester in 1965. According to a 1966 MRC report, 'Mr. McCulloch (social worker) is continuing work on cases of attempted suicide and is now investigating families in which several members have made such attempts but he appears to miss the collaboration of Dr. Kessel who was particularly interested in this subject.'[117]

PSWs, 'attempted suicide', transference and drama
The role of the PSW in fabricating a 'social nexus' around a patient is put into context by Noel Timms in 1964 when he notes that a 'considerable number of referrals by psychiatrists are still requests for a social history, and a considerable amount of time is spent by psychiatric social workers in carrying out such requests.'[118] Social histories, or social workers' case histories are, according to McCulloch and Munro's influential text *Psychiatry for Social Workers* (1969 and 1975)

> 'a most important element in understanding the patient and his illness… As we have seen, treatment in psychiatry is not solely concerned with the patient. It is concerned with the patient in his total environment which includes his family, his home, his work and all other areas of his existence that affect his mental well-being… it is necessary to learn a great deal about the patient's social constellation.'[119]

Munro and McCulloch show how this 'social constellation' is changing during the 1960s with their advice that '[u]nless financial hardship is patently a factor in the patient's mental disturbance it is not usually necessary for the psychiatrist or the social workers to obtain

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[113] Ibid.
[114] Carstairs [?] 'Progress Report 1960-64' p.5, TNA: PRO: FD 12/408.
[115] Faulkner 'Note on visit' p.4.
[116] Ibid. p.2.
[117] Margaret Gorill, 'Visits to Unit by HQ Staff' dated 18/01/1966, TNA: PRO: FD12/408.
[118] N. Timms, *Psychiatric Social Work in Great Britain, 1939-1962* (London: Routledge & Kegan Paul, 1964), p.117.
[119] Munro and McCulloch, *Psychiatry for Social Workers*, p.68.

minute details of family income and expenditure.'[120] In addition, it is 'not enough to record the district or municipal ward in which the patient lives as an indicator of his social status' due to housing shortages, housing policy and increased social mobility. Instead, 'it is better to discover whether the patient is suited or unsuited to his home area and whether he and his family are happy to conform to the prevailing standards of the neighbourhood.'[121] From implied previous concerns around poverty and fixed urban spaces (which are also traditional *sociological* concerns), the issue becomes one of *adequate psychological adjustment* within any given social environment. 'This account of the patient in his social milieu is a valuable background to the more detailed information on the patient's emotional environment which the psychiatrist will gather from the patient himself.'[122]

Given McCulloch's interest in the subject, it is unsurprising that *Psychiatry for Social Workers* should accord a special place for social worker interviews around 'attempted suicide.' In the text, they note that 'we [have already] described a schema for a standard social history, but in the case of attempted suicide there is a good deal of additional information which must be obtained before the significance of the attempt can be adequately assessed.'[123] Thus there is extra practical labour required in order to situate the 'attempted suicide' securely as 'social', to fabricate a 'social constellation' around it. They note '[w]e have mentioned the special need for urgency in the case of attempted suicide… attempted suicide often occurs in the setting of an acute social and psychiatric crisis... In order to obtain an *accurate account of the complex precipitating factors*, the patient's environmental circumstances and the amount of help otherwise to be expected from the relatives, *a social history is necessary straight away*.'[124] Whilst the 'acute social and psychiatric crisis' is merely often present, the presence of 'complex precipitating factors' which are fundamentally tied to the attempts to uncover them, are simply presumed to inhere in the 'environmental circumstances.' More practically, they set out a scheme for the recording of data for the specific occurrence of 'attempted suicide':

> 'In attempted suicide in general, the following points should be noted: ... 2. Did the patient give any indications of intent and, if so, were these recognized and acted upon by others? ... 6. How was the patient discovered and by whom, and who effected his admission to hospital? 7. What were the circumstances in which the attempt occurred and what steps did the patient take to ensure or avoid

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[120] Ibid., p.76.
[121] Ibid.
[122] Ibid.
[123] Ibid., p.201.
[124] Ibid., p.73. Emphases added.

discovery? ... 9. In what way have the key relatives or acquaintances reacted to the occurrence?'[125]

This is a revealing didactic practice for the consistent fabrication of a social environment around a presumed 'attempted suicide'. Another specific effect that PSWs have on the production of 'self-poisoning' concerns a relationship between a method of eliciting data and the 'distress' that is so central to Kessel's object. He argues that the interviews carried out by a clinical team at Ward three are 'a valuable service' and 'highly therapeutic'.[126] He stresses that despite these therapeutic effects, 'no formal psychiatric treatment is undertaken in the ward.'[127] This argument for the 'therapeutic' nature of a process where PSWs are prominent seems to be, at least implicitly, a political intervention, with debate ongoing in the early 1960s as to whether PSWs are 'therapists' or not.

This debate has its roots most firmly in the practical arrangements around child guidance. 'Within psychiatric social work, child guidance had long been seen as the most prestigious field of work because the PSW could claim to be undertaking psychotherapeutic treatment with the mother of the child, often portrayed as a patient in her own right.'[128] The mother brings a child to the clinic, and the child is seen by the psychiatrist, leaving the mother and the PSW alone, a practical arrangement that constitutes fertile soil for the therapeutics of PSW practice. However, this has implications wider than simply child guidance. Vicky Long notes that in the first issue of the *British Journal of Psychiatric Social Work* (in 1947):

> 'Margaret Ferrard, who was employed by a psychiatric hospital, coined the phrase "psychiatric social treatment", to distinguish her work from psychiatric treatment carried out primarily from a medical standpoint. She argued that if a PSW was in possession of a professional skill that she "consciously employs with a therapeutic aim, it must logically follow that she is in fact carrying out treatment."'[129]

Irvine mentions that during the 1950s there is 'continuing discussion as to whether PSWs were primarily social workers or therapists. Many of them, particularly those in child guidance clinics regarded their work as what Florence Hollis later termed "a psycho-social therapy".'[130] This term seeks to delineate and encompass the diverse and unspecific positive effects that social work intervention, guidance and help may have upon a person's mental wellbeing. Noël

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[125] Ibid., pp.201-202.

[126] Kessel, McCulloch, and Simpson, "Psychiatric Service," p.987-988.

[127] Ibid.: p.985.

[128] Long, ""Good Deal to Be Done"," p.238.

[129] M.L. Ferrard 'Notes on the Psychiatric Social Treatment of Mental Hospital Patients: Four Paranoid Schizophrenics' *BJPSW* 1, 1 (1947) p.45 quoted in Ibid.: p.231.

[130] Irvine, "Psychiatric Social Work," p.176.

Hunnybun argues that '[u]ndoubtedly, the p.s.w. in all her contacts with people is engaged in work which, in a general sense, is therapeutic… [i]t often happens that in the actual process of telling, in an atmosphere where there is freedom to tell, the difficulties may be seen in a fresh light and may result in changes both in attitude and action.'[131] For Kessel, this therapeutic interview practice helps to cohere and stabilise his reading of 'self-poisoning' through its relationship with 'distress'. 'Distress' is partially constituted as 'lessened' by the interview.[132] So rather than being concerned with 'formal psychiatric content', the practice of the interview (thought by Kessel initially to be a data collection exercise[133]), starts to draw out the concept of 'distress' more explicitly. In a wider sense, this view of the therapeutic potential of the interview process concerns 'transference'. David Armstrong highlights a connection between transference and 'the social' arguing that '[b]oth bacteriological theories of contagion and Freudian theories of transference addressed this new inter-personal target.'[134] In the 1950s and beyond, 'therapeutic transference' resonates most strongly with the work of Michael Balint.[135]

In addition to this therapeutic angle, Kessel sees the 'dramatic' nature of 'attempted suicide' as *requiring* PSW assistance. He claims that GPs confronted with the phenomenon 'will need the services of a psychiatric social worker, so that an informant's account can be obtained in all cases. Very often the patient himself will conceal important information, either so as to extract the last ounce of drama from a situation in which he holds the centre of the stage'.[136] The PSW thus helps to consolidate the 'dramatic' character of 'attempted suicide', by being necessary for the discovery of some form of deceit, which prolongs the drama. The language of 'deceit' also solidifies the self-conscious character of intent. Both the 'distress' and the 'drama' are connected – to a greater or lesser extent – to social work practices.

The present, marriage guidance and managing the boundary of pathology

Kessel's 'distress' is thus rooted in PSW practice. Busfield's previously quoted argument that 'stress' links 'the social' to mental disorder becomes more specific with the claim that it 'focuses not on events in early childhood but on an individual's more immediate situation.'[137] Whilst 'stress' is not necessarily or inherently present-centred, Kessel's modification of

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[131] Hunnybun, "Psychiatric Social Work," p.107.

[132] This could be cautiously linked to the tone of Batchelor & Napier's interviews as 'gentle assistance' Batchelor, "Attempted Suicide," p.196.

[133] '[T]he days when their primary function was seen as collecting data for psychiatrists'. Timms, *Psychiatric Social Work*, p.7.

[134] Armstrong, *A New History of Identity: A Sociology of Medical Knowledge*, p.52.

[135] M. Balint, *The Doctor, His Patient and the Illness* (London: Pitman Medical, 1957).

[136] Kessel, "Attempted Suicide," p.314.

[137] Busfield, *Men, Women and Madness*, p.190. See also introduction.

Batchelor and Napier is of interest in this regard. In a paper published in 1965, Kessel and McCulloch use their concept of 'distress' to modify Batchelor's analysis:

> 'Batchelor (1954) has suggested that those who act impulsively [when attempting suicide] are manifesting an acute frustration reaction and this aspect we recognize. But our impression is that they do it not so much because they are or feel thwarted as because they are distressed… Distress, whether it stems from depression or from intolerable social circumstances, is *always present at the time of the act*.'[138]

As noted in chapter two, Batchelor and Napier's 'acute frustration reaction' is rooted in John Bowlby's ideas of childhood emotional disorganisation and trauma. It is a thread that re-emerges later in 'attempted suicide' studies from University College Hospital.[139] Kessel and McCulloch modify this interpretation, emphasising *present* distress over *past* emotional deprivation. This increases the relevance of the present social environment against the childhood emotional environment. Kessel is also ambivalent about Batchelor and Napier's use of the concept of faulty adaptation: '[w]hether the broken parental home is the root from which stems the disorganized life pattern, the disorganized marriage, the dwelling in disorganized districts, must remain a matter for speculation, but all these four circumstances are often found in the stories of people who poison themselves.'[140] Kessel's vision of distress is present-focussed and intertwined with impulsivity: '[t]wo-thirds of all acts were impulsive... This astonishing finding is of the utmost importance. Five minutes, sometimes only one minute, before the act took place the idea of taking poison was not in the person's mind.'[141] This is clearly a significant shift for Kessel.

Kessel and McCulloch's shift of emphasis shows how psychiatric social work begins to move beyond its child guidance heritage. This is related to marriage guidance, a movement founded in the 1920s and also has significant connections with PSWs.[142] The Family Discussion Bureau is founded in 1948 by the Family Welfare Association and becomes attached to the Tavistock Institute of Human Relations in 1956.[143] Elizabeth Irvine reveals of PSW training schemes that '[t]he psychology of family relations was introduced in the late 1950s, largely taught by members of the Family Discussion bureau (later the institute of Marital Studies), who

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[138] Kessel and McCulloch, "Repeated Acts," p.91. Emphasis added.
[139] See chapter five.
[140] Kessel, SP 1 (1965) p.1268.
[141] Kessel, "Self-Poisoning (2)," p.1337.
[142] For a general history, see J. Lewis, "Public Institution and Private Relationship: Marriage and Marriage Guidance, 1920–1968," *Twentieth Century British History* 1, no.3 (1990).
[143] Heimler, *Mental Illness*, p.55.

sometimes narrowed the subject to marital relations alone.'[144]   Eugene Heimler claims in *Mental Illness and Social* Work (1967) that '[m]any cases of mental illness in adults and maladjustment in children prove to be the outcome of severe marital problems.'[145] These concerns also resonate within psychiatric research, specifically work being done by Norman Kreitman at the Graylingwell Hospital in Chichester around this time. His articles 'Mental Disorder in Married Couples' (1962) and 'The Patient's Spouse' (1964) resonate with the eugenic concerns of Lionel Penrose's Colchester study of 'Mental Illness in Husband and Wife' (1944),[146] and Eliot Slater and Moya Woodside's *Patterns of Marriage* (1951), itself a product of psychiatrist-PSW collaboration.[147]

The increasing marital focus of PSW training from the late 1950s feeds into Kessel's present-centred distress as *current* 'marital disharmony': 'marital conflict is the chief aetiological factor in many cases; generally the attempt follows swiftly upon an acute domestic quarrel in a chronically disturbed matrimonial situation.'[148] Kessel and Lee note that 'Batchelor (1954) showed the importance of the broken home in the patients. We would equally stress the importance of the breaking home.'[149] This theme on marriage is also taken up by John G. Bruhn, a U.S. Fulbright Fellow from Yale, attached to the psychiatric epidemiology MRC Unit at Edinburgh (1961-1962). For him, '[p]erhaps the most important finding was that regarding marital disharmony' which he found in 'an exceptionally high degree' amongst 'attempted suicides'.[150] He links this with Kessel and Lee: '[m]arital disharmony seems to be the most outstanding factor in this study as in that of Kessel and Lee (1962). The role of marital disharmony or of the breaking home cannot be overstressed.'[151] The 'breaking home' is present-focussed, rather than the 'broken home' as a childhood artefact. The aetiology of 'attempted suicide' thus migrates from the past to the present.

Present 'marital disharmony' is only a short step away from broader romantic, *communicative* interpersonal concerns. Kessel argues that:

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[144] Irvine, "Psychiatric Social Work," p.194.

[145] Heimler, *Mental Illness*, p.55. Heimler is an Auschwitz survivor, born in Hungary, who comes to England in 1947, qualifies as a psychiatric social worker in 1953 after attending courses at the LSE and Manchester. After working for Middlesex County Council, set up the Hounslow Project to conduct research into community care in the mid-1960s. Ibid.: unnumbered page.

[146] L.S. Penrose, "Mental Illness in Husband and Wife: A Contribution to the Study of Assortive Mating in Man," *Psychiatric Quarterly* 18(1944).

[147] Their focus on the marriage relationship is rooted in eugenic concerns around 'assortive mating' Slater and Woodside, *Patterns of Marriage*, pp.12-14.

[148] Kessel and Lee, "Attempted Suicide in Edinburgh," p.134.

[149] Ibid.

[150] J.G. Bruhn, "Broken Homes among Attempted Suicides and Psychiatric out-Patients: A Comparative Study," *Journal of Mental Science* 108(1962): p.778.

[151] ———, "Comparative Study of Attempted Suicides and Psychiatric out-Patients," *British Journal of Preventive & Social Medicine* 17(1963): pp.200-201.

'[a]dmission to the ward, having poisoned oneself, can be for instance a powerful weapon in bringing back errant boy friends. The girls who resort to it are, all the same, very much distressed; in their despair they do something stupid and senseless, and it works… Perhaps what we most resent is that, though there was probably a negligible risk to life, they are held by their circle of friends narrowly to have escaped death. They have had their drama; to us it only means work.'[152]

The highly gendered nature of this communication is discussed below. For 'self-poisoning' to be a 'powerful weapon' it must be positioned in a space of personal, intimate, romantic relationships. But it is clear that this intention to communicate with or 'bring back' a 'significant other' involves their 'circle of friends' also. 'Self-poisoning' is rooted in a present social context.

On a practical level, Noel Timms sees in 1964 slight but significant temporal changes in the 'social history': '[i]t is possible that the purpose and method of taking the social history have changed, since psychiatric social workers now think they are called on not so much for a detailed expression of family history but for an assessment of the present situation or a clarification of particular aspects of that situation.'[153] More theoretically, Eugene Heimler argues that

'[i]n community care the present plays an extremely important part. The psychiatric social worker tries to enable his patient to function better in his present life and uses the present as a therapeutic tool… *Man therefore, is not only a product of what he was but also of what he does*… In short, the theory of psychiatric community care is this: the past influences the present, but the present also influences the past.'[154]

Munro and McCulloch's section on history taking also shows the growing influence of the present. Under the PSW's heading 'Home Circumstances' should 'be described the circumstances which are typical of the patient's current life rather than those which were present in his earlier years.'[155] This is not to claim that longer-term factors cannot co-exist with this present focus, through such devices as 'predisposing factors',[156] or Hopkins' 'precipitating' and 'conditioning' causes.[157] The point is to show how shifts in social work practice, articulated

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[152] Kessel, "Self-Poisoning (2)," p.1337.
[153] Timms, *Psychiatric Social Work*, p.117.
[154] Heimler, *Mental Illness*, pp.118-119. Original emphasis.
[155] Munro and McCulloch, *Psychiatry for Social Workers*, pp.75-76.
[156] E.g.'[a]lcoholism is a major factor predisposing to self-poisoning.' Kessel, "Self-Poisoning (1)," p.1270.
[157] Hopkins, "Attempted Suicide," pp.86-88.

through concepts of 'distress' impact upon a clinical phenomenon. The present-centred concerns of the mid-1960s throw the work of Batchelor and Napier into sharp relief.

Kessel's rooting of the action in this broad present-focused 'distress' is part of a complicated relationship between abnormal action and psychiatric pathology: '[i]t has often been argued that to poison oneself is such an abnormal act that everyone who does so must be psychiatrically ill. We have not fallen into that tautological trap, for to contend thus is to make the recognition of psychiatric illness no more than a dependent phenomenon.'[158] The management of the troublesome borderline comes into focus when mental illness is intertwined with and projected onto 'the community'. The position of Kessel's 'distress' as negotiating the uncertain boundary of psychopathology is clear: '[d]istress drives people to self-poisoning acts, and distress is not the exclusive province of the mentally ill.'[159] This tallies with Armstrong's analysis that 'stress' is used as a concept in order to get a handle upon an 'ambiguous borderline' that results from a relational conception of mental illness, being elastic enough to be able to straddle pathology and normality. Armstrong claims that 'the borderline case became an accepted category in the community prevalence studies. It was the classification which, in practical terms, made the problematic boundary between normality and pathology manageable' but it is still a 'basically unsatisfactory category.'[160] Social work is vitally important, because it is seen to offer therapeutic possibilities across that boundary. Kessel claims that '[i]t does not follow that the patient can benefit from treatment only if he has a psychiatric illness. Nearly half of those without such illness were judged to be helpable by further care, a term which embraces social work as well as psychiatric therapy.'[161]

This concern with the 'borderline' between mental health and illness forms a central part of the entire research unit from which Kessel's studies issue. Carstairs informs the MRC in 1966 (after Kessel's resignation) that 'an attempt was being made to find a unifying theme for the Unit's programme of research and this, broadly speaking, was to find out what caused some people to carry on adequately in the face of various stresses, even while exhibiting symptoms of neurosis, while others with similar stresses and symptoms broke down entirely.'[162] This is elaborated upon by unit psychologist Graham Foulds, who 'said that he hoped to take a large random sample of the general population, defined only by age and sex, from general practitioners' lists. Each person would be studied by means of various psychological tests and rating scales and each would be re-examined at intervals to try to identify the "carriers-on" as

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[158] Kessel, "Self-Poisoning (1)," p.1269.
[159] Ibid.
[160] Armstrong, *Political Anatomy*, p.97.
[161] Kessel, "Self-Poisoning (1)," p.1270.
[162] Gorill 'Visits to Unit' 18.01.1966.

distinct from the "breakers-down" and the reasons for the difference.'[163] The centrality of 'the social' to Foulds' rating scales is evident in his claim that '[s]ince the person is only a person in relation to others, such illnesses [neuroses and psychoses] can usefully be viewed, *inter alia* [among other things], as increasing degrees of failure to maintain or to establish mutual personal relationships.'[164]

The focus upon marital relationships also has a significant role in managing the uncertain boundary of pathology covered by 'distress'. Kessel states that '[o]f particular importance is the fact that 26% of the men and 20% of the women ['self-poisoners'] had no psychiatric illness.[165] However, the pathology does not disappear, but a marital focus within the social constellation allows pathology to be projected onto somebody who has not even been poisoned. McCulloch and Philip put this most clearly in 1972:

> 'the Edinburgh studies have shown that among married women pathological jealousy in the husband was found in almost a quarter of the cases. Indeed, the persistent suspicions of the "jealous husband" were frequently found to be a precipitating factor for the attempt. In all but a tiny proportion of such cases, the husbands themselves reported that their jealousy had been completely unfounded.'[166]

This idea of illness emerges right at the point where marriage guidance and psychiatry intersect. The marriage relationship features in an intriguing passage from a 1947 article by anthropologist Adam Curle and industrial psychologist Eric Trist where, although the marital connection is seen as beneficial, it is still a special conduit for things potentially psychopathological: '[f]or many of those whose restricted pattern of social relationships is associated with feelings of discontent, anger, or bitterness, the marital relationship may be the only social relationship sufficiently real and secure to permit the expression of such hostile feelings to another human being.'[167] The idea of 'the jealous husband' is given an entire

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[163] Ibid. This planned 'Population Laboratory' is never realised, but represents the most ambitious attempt at the time to scrutinise this unstable boundary of mental pathology by means of psychometric testing. It never advances beyond the draft stage before Kessel's resignation, and is roundly criticised by a number of referees, including Martin Roth, Jerry Morris, Richard Doll, Denis Hill, Eliot Slater and Aubrey Lewis. See W.I.N.K. [N. Kessel] 'Personality and Psychological Illness, a Prospective Study 'Preliminary Draft', November 1964 p.1 , TNA: PRO: FD 12/409.

[164] Foulds et al., *Personality and Personal Illness*, p.3. Strangely, this 'population lab' is not seen as a great change by the MRC, as it is not until a central committee visits the unit in 1969 that 'a dominant theme… in the studies on suicide' is said to have emerged. 'MRC Unit for Epidemiological Studies in Psychiatry: Reconstitution of Unit' TNA: PRO: FD 12/412.

[165] Kessel, "Self-Poisoning (1)," p.1269.

[166] McCulloch and Philip, *Suicidal Behaviour*, p.20.

[167] Curle and Trist, "Transitional Communities and Social Reconnection," p.283. Quoted in Hayward, "Sadness in Camberwell [Draft]."

chapter in J.H. Wallis' influential *Marriage Guidance: A New Introduction* (1968). Wallis ends his description with '[t]he important question [of] whether this client may need psychiatric treatment' and concludes with a reference to that same problematic boundary line: '[t]here cannot be a categorical answer to this question since the dividing line between sickness and health is not precise. One has to consider the whole situation'.[168] 'The social', psychiatric treatment and the negotiations around formal psychiatric pathology link psychiatrists, PSWs and marriage guidance counsellors around this object of 'self-poisoning'. [169] In any case, the marital relationship is subject to intense psychiatric scrutiny, enabled, as Hayward has it, by 'detailed interviews and follow-up investigations',[170] or in Kessel's phrase, by 'putting together' clinical and social details.

'Distress', 'domesticity' and gendered self-poisoning

These practices are saturated with stereotypes of femininity. In one sense, it is most obvious in the 'population-level', epidemiological differentiation between attempted and 'successful' suicide.[171] In a more clinical or social setting, it is a highly uneven process, left unexplained or unmentioned; as Raymond Jack rightly points out the issue has 'been virtually ignored in the literature.'[172] There is certainly nowhere near as much crude gender stereotyping as that which pervades a rather different 'cry for help', the North-American-based 'delicate self-cutting' of the late 1960s and early 1970s.[173] All three of Kessel's developments and modifications that make 'self-poisoning' distinctive ('self-consciousness', 'poisoning' and 'stress') have *potentially* gendered freight.

The additional 'self-consciousness' can feed into stereotypes of feminine manipulation, exemplified by Kessel's 'errant boy friends' comment above. 'Self-poisoning' is seen as a 'passive' (read: feminine) method which interacts with a gendered imbalance in the prescription of barbiturates. As Ali Haggett states, '[s]ince the 1970s, feminist historians have suggested that the lack of opportunities afforded to women and the banality inherent in the domestic role caused symptoms of anxiety and depression in post-war housewives. Correspondingly, they have argued that the primary motive for prescribing psychotropic drugs

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[168] J.H. Wallis, *Marriage Guidance: A New Introduction* (Routledge & K. Paul, 1968), p.105.
[169] Additionally, Michael Shepherd writes 'a major paper' in the early 1960s on 'Morbid Jealousy' and was assisted by Greer. P. Crichton, "In Conversation with H. Steven Greer," *Psychiatric Bulletin* 24, no.5 (2000): p.190. See M. Shepherd, "Morbid Jealousy: Some Clinical and Social Aspects of a Psychiatric Symptom," *The British Journal of Psychiatry* 107, no.449 (1961).
[170] Hayward, "Sadness in Camberwell [Draft]."
[171] See 'Textbook emergence' in the introduction.
[172] Jack, *Women and Attempted Suicide*, p.ix.
[173] Millard, "Self-Mutilation". Brickman, ""Delicate" Cutters."

was to ensure that women "adapted" to their domestic role.'[174] Finally, 'distress' has resonances with a feminine emotionality, but is also explicitly accessed and articulated as part of this feminised 'domestic role'.

The projections enabled by psychiatric social work practice, principally around 'distress', interact further with marriage concerns, in a domestic-centred way. Indeed, Kessel makes 'the emotional' a cornerstone upon which he can build a 'domestic space' in this fascinating (and explicitly normative) gendered passage:

> 'There is no simple explanation of the high rate of self-poisoning among young women in their early twenties… These women, although fully engaged in their normal social setting, mothering and running a home, are emotionally isolated… they have not yet had time to adjust to the confines of domesticity... Unhappiness mounts, and then suddenly explodes, at a moment of special crisis.'[175]

This recalls Slater and Woodside's observations of the latter's home-interviews of the wives of selected soldiers in the late 1940s, where Woodside reports witnessing 'struggles and ambitions eventually adapting themselves to the limitations of a restrictive environment.'[176] This is not new; marriage, domesticity and psychopathology are historically well-connected.[177] In addition, this general 'emotional isolation' and 'normal social setting' is opened up at the intersection of marriage concerns and PSW practice: spouse interviews.

> 'We noted one phenomenon over and over again. An insensitive spouse, generally the husband, although he cared for his wife had failed to notice either her need for emotional support and encouragement or the growing sense of isolation within the home that stemmed from their lack.'[178]

Domestic stress is still gendered, not through 'maternal deprivation' but through a feminine lack of resilience, or a masculine lack of support. These gendered lacunae affect Kessel's way of framing and answering questions: '[c]onfirmation was thus provided of the clinical impression derived from dealing with the patients, especially the women in the ward, that

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[174] Ali Haggett, "Housewives, Neuroses and the Domestic Environment in Britain, 1945-1970," in *Health and the Modern Home*, ed. M. Jackson (Abingdon: Routledge, 2007). See also R. Cooperstock and H.L. Lennard, "Some Social Meanings of Tranquilizer Use," *Sociology of Health & Illness* 1, no.3 (1979).

[175] Kessel, "Self-Poisoning (1)," p.1267.

[176] Slater and Woodside, *Patterns of Marriage*, p.15.

[177] Nikolas Rose notes nineteenth-century medical '[e]ncounters within the domestic space, with the hysterical wife'. Rose, "Medicine, History and the Present," p.57. A classic statement is E. Showalter, *The Female Malady: Women, Madness and English Culture 1830-1980* (London: Virago, 1987).

[178] Kessel, "Self-Poisoning (2)," pp.1336-1337.

marital conflict is the chief aetiological factor in many cases'.[179] The practice of holding a 'clinical conference' with PSWs at Ward 3 has emerged and solidified by February 1963, when a letter from Kessel to the *Lancet* advises that in all cases of 'attempted suicide' a friend or family member of the patient should be interviewed by a member of the team, which is done by a PSW at Edinburgh. Kessel shows that the practice had been adopted unevenly, but was now strictly enforced: '[t]ime and again we found that we erred before we made this a rule'.[180] This cooperation brings in credible information, accessed by interview with somebody who is not a patient, opening up a space where Kessel's casual 'clinical impression' can gain empirical validation or confirmation.[181] It shows the interaction between the marital and family concerns that run through the Edinburgh work on self-poisoning, and a specific professional interview practice. Crucially, this enables Kessel to speak about domestic space through what is observed in a hospital ward. Once Kessel's clinical impression is confirmed, it can predominate, even to the point of overriding PSW input that helps to enable it: '[t]he psychiatric social worker, who had seen both partners, graded only half the marriages as poor or bad... Perhaps, however, one has to be inside a marriage really to assess its satisfactions and its failures.'[182]

This allows projection onto marriages, spouses and homes. The 'clinical conferences' (allied to Kessel's 'clinical impression') produce ideas of a socially situated 'self-poisoning' due to the availability of PSWs (even whilst their input is sometimes overridden). Visions of 'the home' are created in these analyses, and co-constituted with the aetiology of 'self-poisoning', as a small but significant part of the wider project that inscribes mental health and mental disorder onto the social, interpersonal fabric of everyday life. This pathological domesticity is crucial in stabilising and explaining the phenomenon as the decade progresses.[183]

The unequally-gendered archetype of 'self-poisoning' is tackled explicitly by Kessel, who asks whether self-poisoning is 'perhaps the female counterpart of delinquency in young men? Such a hypothesis would suggest that women turn their aggression against themselves, while men act against society.'[184] However, he is not in favour of this argument and instead argues that '[c]linical study' leads him to explain 'self-poisoning' through the 'emotional isolation' and failure to adapt to the 'confines of domesticity' quoted above. Through his rehearsal and rebuttal of a 'delinquency' hypothesis, Kessel explicitly demonstrates a move away from conventional, significantly masculine, sociological concerns (such as crime, delinquency and

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[179] Kessel and Lee, "Attempted Suicide in Edinburgh," p.134.
[180] N. Kessel, "Attempted Suicide," *Lancet* 281, no.7278 (1963).
[181] Kessel feels strongly enough to include the results of these non-clinical interviews with his other statistics. Kessel, "Self-Poisoning (2)," p.1336.
[182] ———, "Self-Poisoning (1)," p.1267.
[183] See chapter five.
[184] Kessel, "Self-Poisoning (1)," p.1267.

deviance), to a position made possible by the PSW-founded interrogation of 'the domestic' (disguised here within the term 'clinical study'). This is a crucial component of his rendering of female-dominated 'self-poisoning.' But it is not enough just to state (and lament) the traditional association or, more precisely, mutual constitution of the domestic with femininity. For sexism is active practice, not merely a rearticulation of established associations, and these practices go right to the heart of psychiatric social work practice itself, not just the domestic imaginings that it enables.

This domestic, family focus is further strengthened by a change pioneered in Scotland: generic social work. In 1964 the Kilbrandon Report[185] recommends the integration of Children's Officers and Probation Officers in Scotland, a recommendation that acts as a catalyst for much wider social service reforms towards generic, rather than specialist social work provision.[186] This leads to the 1966 white paper *Social Work and the Community* which broadens out the principles of the Kilbrandon Report and becomes, for Scottish social work, 'the foundation stone of the modern profession and the definitive statement of the place of the social work function in government'.[187] The recommendations are turned into legislation in the Social Work (Scotland) Act (1968). The principles of generic social work provision are later propounded in England and Wales by the Seebohm Committee's Report, most of which becomes the *Local Authority Social Services Act* (1970). Broadly, these changes herald a reconceptualization of social work from being 'lubrication' in the 'machinery' of the welfare state (Barbra Wootton's memorable metaphor), to being at 'the centre of social welfare', characterised as 'comprehensive, universal, professional, impartial and subject to democratic political control'.[188]

This signals the end of the specialist PSW, but an upward surge in the influence of what Rose has called 'therapeutic familialism'. This is achieved by cohering all the different strands of social work (probation officers, children's officers, PSWs, child guidance, home help, etc.) into 'a nexus that bore on the family case as the site for policy.'[189] Writing in 1972, Smith and Harris identify the tendency of both the Kilbrandon and Seebohm reports 'to regard the family, and

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[185] L. Kilbrandon, "Report of the Committee on Children and Young Persons (Scotland)," (Edinburgh: Scottish Home and Health Department and Scottish Education Department 1964).
[186] I. Brodie, C. Nottingham, and S. Plunkett, "A Tale of Two Reports: Social Work in Scotland from Social Work and the Community (1966) to Changing Lives (2006)," *British Journal of Social Work* 38, no.4 (2008): p.699.
[187] Ibid.: p.698.
[188] J. Harris, "State Social Work: Constructing the Present from Moments in the Past," *British Journal of Social Work* 38, no.4 (2008): pp.669, 671; Wootton, *Social Science and Social Pathology*, pp.298-299.
[189] Rose, *Governing the Soul*, p.179.

to a lesser extent the community, as the basis of social need.' [190] The Kilbrandon Report is centred upon domesticity through a model of the natural developmental capacities of the home:

> '[t]he underlying aim of all such measures must always be, wherever possible, to strengthen and further those natural influences for good which will assist the child's development into a mature and useful member of society. The most powerful and direct of these influences lies in the home'[191]

As this report forms the 'cornerstone' of the move towards generic social work practice, the domestic pathology at the centre of 'self-poisoning', accessed and underpinned by social work expertise, gains in resonance as the decade progresses. This domestic imagining, this projection from hospitals and wards, accessed by PSWs, enables 'attempted suicide' more generally to be rooted in a social space, and allows the social space to *cause* 'attempted suicide'.[192]

Of course, significant gender differences operate outside of social work. In the classic *Psychiatric Illness in General Practice* it is reported that '[m]ost of the social factors listed were concentrated among the female attenders… Taking into account the over-all excess of female psychiatric cases, it would be a justifiable exaggeration to say that in the eyes of the general practitioners, psychiatry in general practice consists largely of the social problems of women.'[193] A gender imbalance in 'attempted suicide' does not seem exceptional in the wider context of reading mental illness into interpersonal relationships. If what Jacques Donzelot claims of France is true of Britain – that 'the social' as an autonomous realm is first fabricated around 'the family'[194] – then the historically gendered character of the 'family sphere' might provide part of an appropriately historical answer.[195] The idea that those gendered 'women' are physically, emotionally, psychologically or evolutionarily more suited to domestic, home or family spaces is a durable plank in circular sexist arguments that gender domesticity 'feminine' *a priori*. It is important for historical work to uncover these rearticulations and to trace and critique their consequences.

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[190] G. Smith and R. Harris, "Ideologies of Need and the Organization of Social Work Departments," *British Journal of Social Work* 2, no.1 (1972): p.29.

[191] Kilbrandon, "Kilbrandon Report," para.17.

[192] See chapter five for a development of this idea.

[193] M. Shepherd et al., *Psychiatric Illness in General Practice* (London: O.U.P., 1966), p.149.

[194] J. Donzelot, *The Policing of Families* (New York: Pantheon Books, 1979).

[195] L. Davidoff and C. Hall, *Family Fortunes: Men and Women of the English Middle Class, 1780-1850*, 2nd ed. (London: Routledge, 2002). Amanda Vickery engages in a robust critique, arguing that the language of 'separate spheres' has limited purchase as an *explanation for change*, as such spheres 'can be found in almost any century we care to look'. A. Vickery, "Golden Age to Separate Spheres? A Review of the Categories and Chronology of English Women's History," *Historical Journal* 36, no.2 (1993): p.412.

The gendered imbalance is rooted in understandings of home, as child and maternal bonds receive an increasing level of criticism after the mid-1960s. As Rose argues:

> 'In the 1940s and 1950s those who rallied round the cause of motherhood and deprived children considered themselves progressive and humanitarian, in touch with the latest scientific evidence on the nature of the family… But in the mid-1960s this amalgam of theoretical systems professional practices, legislative measures, social provisions, and public images – this "maternal complex" – came under attack. Historians and sociologists challenged the universality of the mother-child bond, and hence its claim to be "natural"… Feminists criticized it as little more than a means of enforcing and legitimating women's socially inferior position and their exile from public life.'[196]

However, during Kessel's time at Edinburgh, such critiques are far from the mainstream, and even afterwards, struggle to make much headway in psychiatry. On a number of levels then, from the 'neat' pattern of a completed / attempted suicide split that is made to correspond to some gendered essence – tackled by Howard Kushner – to the passivity of a 'cry for help' (noted by Raymond Jack), and the gendered freight of the very concept of 'the social' (Donzelot) is added the imbalances of PSWs, child guidance and marriage guidance which articulate a very domestic distress.

There is in the work of Kessel and collaborators a move from the gendered imbalance signalled by Bowlby's 'maternal deprivation' (which Batchelor and Napier significantly extend to fathers[197]) to a focus on pathological marriages and homes where a specifically feminine aspect to 'self-poisoning' emerges much more strongly. 'Broken homes' are seen to affect both genders more or less equally, but this is not the case for *present* domestic problems. This reassertion of gender differentiation is connected to an increased reliance upon social work, which has a gendered dynamic of its own.

John Stewart notes that during the interwar period, 'social work was… a predominantly female occupation',[198] and Irvine hints at gendered difficulties during the 1950s, when DAOs (Duly Authorised Officers) and PSWs begin to converge in their focus upon the mentally ill outside the confines of the psychiatric hospital. Irvine argues that '[t]he DAOs, who had much to learn [from PSWs], were reluctant to learn it from relatively inexperienced rivals, most of whom

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[196] Rose, *Governing the Soul*, p.180.
[197] See chapter two.
[198] Stewart, ""See His Home"," p.117.

were women… Relations with psychiatrists were frequently a problem.'[199] In the post-War period Noel Timms again calls psychiatric social work 'a predominantly female profession'.[200] Of course, the presence of those coded 'women' in any given profession does not necessarily mean that the work produced will be 'gendered' in any particular way. The problem arises from the gendered assumptions that are articulated through the imagery and associations of a 'female profession'. The child guidance roots of PSWs carry significant gendered freight,[201] and Timms is aware of the gendered belittling of PSWs by psychiatrists. He recalls an article in the *BMJ* in 1950 on 'The Role of the Psychiatric Social Worker' where:

> 'Dr J.B.S. Lewis appeared to give full recognition to the psychiatric social worker. "She should", a report of the meeting states, "of course, work in close conjunction with a psychiatrist; but it must be remembered that she had a skill of her own, and he could learn from her as she from him. Her duties were multifarious. She had to explain to the patient, his relatives, employers, etc. what the hospital or clinic was doing; to take a social history; to follow-up and help discharged patients; to co-operate with other social services; to help in administration and therapeutic work and in research; and, in fact, to carry out many *other chores*."[202]

This earnest and patronising picture is assessed with Timms' sardonic comment '[t]he fairly high status accorded to the psychiatric social worker is somewhat diminished by the ambivalent comment in (my) italics.'[203] Scrutiny of domesticity is elided into domestic work ('chores'). The sexism upon which pathological domesticity is founded is the same sexism that saturates the profession of psychiatric social work. In all of Kessel's moves, from self-poisoning to self-consciousness to domestic distress, the gendered character emerges, hand in hand with a patronised profession of PSWs sent into the home space to bring it back for the psychiatrist's reimagining.

Concluding thoughts

Kessel's project on 'self-poisoning' comes to an abrupt end in 1965 when he takes up the Chair in Psychiatry at Manchester University. However, his work at Ward 3 has enduring resonance for 'attempted suicide' more generally. It is the first time that really sustained research resources are focussed upon the phenomenon at a site of secure, mixed therapeutic

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[199] Irvine, "Psychiatric Social Work," p.179.

[200] Timms, *Psychiatric Social Work*, p.126.

[201] Due principally to the widespread assumption found in Shepherd et al. '[s]ome factors listed are understandably more significant to women; for example child management' Shepherd et al., *Psychiatric Illness in General Practice*, p.149.

[202] Timms, *Psychiatric Social Work*, 112-113. quoting J.B.S. Lewis 'The Role of the Psychiatric Social Worker' British Medical Journal (July 28th 1950).

[203] Ibid., p.113.

approaches. This object is given further importance at Edinburgh because of a number of arrangements that allow Ward 3 patients to form a 'complete' sample for the city. The publicity around 'suicidal behaviour' in the suicide law reform helps this phenomenon achieve wider prominence. However, the purpose of this chapter is to show how a high level of research scrutiny that embeds a 'physical injury' into a 'social situation' is not abstract. The practical, *historically situated* arrangements that enable such credible scrutiny have a fundamental effect on the kind of psychological object that emerges from the transformation.

The various assumptions and methods of sense-making in this transformative expertise (including sexism, marriage guidance, and focus on the present) are inextricable from 'attempted suicide'. This phenomenon of 'attempted suicide' is a prominent expression of, and driver for, the broad and eclectic turn to 'the social' in mental health; this 'social' still undergirds the controversial justifications for 'community care'. The practical arrangements carried out in hospitals in the mid-late 1960s show how the psychiatric epidemiology MRC Unit is just a particularly bright spot in an increasingly varied field. Kessel is influential, but the phenomenon is on a much larger scale. However, this also brings significant problems outside of such established and insulated therapeutic mixtures as 'Ward 3'.

Chapter 5: New integration, new conflict and neologism (1965-1969)

Minister of Health Enoch Powell's *Hospital Plan for England and Wales* (1962) is a familiar landmark in twentieth-century psychiatry.[1] His 'water tower' speech to the National Association of Mental Health eloquently launches the ideas contained within the *Plan* in 1961.[2] It is an evocative portrayal of asylums as grand obsolete monuments to Victorian ideas of mental healthcare. There is much historiographical focus upon how the *Plan* (drawing upon an article by G.C. Tooth and Eileen Brooke[3]) augurs the scaling back of mental inpatient provision, but much less on how it signals the broader uptake of a new model of integration between psychiatry and general medicine.[4] This model involves a more intimate connection between general hospitals and psychiatry than observation wards, specifically the establishment of psychiatric units in district general hospitals (DGHs), as well as the much recycled 'care in the community' slogan accompanying the gradual running down of the asylum system. The DGH psychiatric units that the plan promotes undercut the progressive status and bridging function of the observation ward.

The combined facilities for psychiatric evaluation and resuscitation (as well as access to PSWs) available at Edinburgh's Ward 3 are not widespread. It is not until around 1965 that increasing numbers of studies, detailing consistent psychiatric referral and psychosocial scrutiny of physically injured patients, begin to emerge. This chapter analyses how a number of different hospitals begin to focus in this way upon a communicative 'attempted suicide'. In addition three studies emerge in 1965-66 with significance for General Practitioner studies of 'attempted suicide'. These show how the organisation of healthcare in Britain makes it difficult and unlikely for 'attempted suicide' to come under extended scrutiny in this area.

A variety of referral practices, shown in the studies analysed below, demonstrate again how a certain kind of (socially-directed) 'attempted suicide' emerges according to the practices used to bridge the gap between separated therapeutic approaches of general and psychological medicine. However, whilst this does lead to an increasing number of studies producing a socially embedded 'attempted suicide', it also shows the limits of how far these approaches can converge upon patients. The approaches of general medicine (as well as specialisms such

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[1] E.g. P. Sedgwick *Psychopolitics* (London: Pluto Press, 1982), p.104; Rogers and Pilgrim, *Mental Health Policy in Britain*, pp.64-65.

[2] E. Powell, *Emerging Patterns for the Mental Health Services and the Public* (London: National Association for Mental Health, 1961).

[3] Tooth and Brooke, "Mental Hospital Population."

[4] See chapter three.

as surgery), are arranged and administered very differently to psychological medicine inside DGHs. These approaches remain persistently separate, and the new arrangements designed to bridge this gap and focus psychiatric scrutiny on physically injured patients provoke conflicts over resources.

The second half of this chapter describes the ways in which these conflicts (partially a result of closer accommodation) lead to the further entrenchment of 'attempted suicide' in psychopathological domestic space. This shift is partially explicable as a tactical response to therapeutic conflict: psychological medicine can use this 'pathological domesticity' to reinforce the significance of psychological factors in 'attempted suicide', and thus buttress the arguments for psychiatric referral. The domestic, social pathology that is produced as a *result* of psychiatric referral and scrutiny becomes entrenched enough, and presumed on a wide enough scale, to be deployed as another *reason* to secure such scrutiny.

This entrenchment, this presumption of domestic psychopathology, helps to illustrate how behavioural objects become established. The 'social constellation', the domesticity fabricated by PSWs in the previous chapter, appears stable and reliable enough to be *presumed* around physical injury. Thus the communicative nature of the object becomes stable, because communication requires some form of recipient. Once stable, the object becomes *self-confirming*, as the more 'obvious' or 'given' this 'communication' becomes, the more effort is expounded to uncover and construct a communicative motive. Finally, the object passes from being an object with crossover and scrutiny and new fields of vision at its base, to being a socially-embedded, distress-expressing 'attempted suicide' as a resonant, increasingly *available* option. That is, when 'an overdose of medication as response to interpersonal conflict' becomes stable and widely known, more people will use the 'overdose' as a response to such 'interpersonal situation'. It becomes an available, and widely *intelligible* response, of 'epidemic' proportions. The thesis ends with the proposal of the neologism 'parasuicide' which expresses – even in the proposed change – a stability, consensus and availability around the clinical, social, psychological object.

Observation ward to DGH unit: practical integration and new crossover

As seen in the build-up to the 1959 Act, rhetorical efforts *equate* 'mental' with 'physical' medicine and prioritise therapeutic provision in the same spaces. These fuel the legislative efforts that *enable* publicly-funded mental therapeutics on the same deregulated basis as 'physical care'. In terms of institutional practice, the integration of 'psychiatric' with 'general' medicine is not only attempted by casualty referrals, but the provision of psychiatric treatment

units in DGHs. These units owe much to observation wards – in many cases, the wards *become* treatment units. Further potential for the object 'attempted suicide as cry for help' emerges through these units that effect high intensity psychiatric scrutiny upon general hospital patients.

There is little historiographical agreement on the precise timing of these changes. John Pickstone notes 'the tendency, from the 1960s, to place psychiatric units in general hospitals.'[5] Martin Gorsky, pushing it back a little, characterises these developments as '1950s antecedents to community care... and peculiar local factors which first favoured small psychiatric units in district general hospitals rather than asylums.'[6] Sensitive analysis of the proliferation of psychiatry around general hospitals, and its importance for the transformations that undergird 'attempted suicide' requires an acknowledgement of Gorsky's implied warning against obsessive focus upon 1959 as a year of great change. Maclay goes so far as to claim that this 'new' trend for psychiatric units in general hospitals 'is really the reestablishment of an old pattern... In Scotland, general hospitals treated patients until the latter half of the 19th century'.[7] C.P. Seager argues in 1968 that '[t]here have always been a large number of patients suffering from psychiatric illness treated in general hospitals. For a long time a large proportion of these were there by accident.'[8] Now their treatment there is self-consciously attempted.

The Ministry of Health's role in this process is well established, but observation wards are conspicuous by their absence. Roy Porter argues it is part of Powell's *Hospital Plan* 'that the old mental hospitals... should be scaled down or closed down, and that those requiring inpatient treatment should be treated by local hospitals.'[9] These units are a key plank in the government policy of scaling back mental hospital provision. The *Hospital Plan* states that '[i]t is now generally accepted that short-stay patients should be treated in units nearer to their homes than is generally possible with large, isolated mental hospitals, and that it will usually be desirable to have these units attached to general hospitals.'[10] One clinician observes in 1963 that '[f]ollowing the Mental Health Act... [w]hatever views may be held regarding the role of general hospital psychiatric units, they are increasing in number and influence, and

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[5] Pickstone, "District General Hospitals," p.186.

[6] Gorsky, "British N.H.S.," p.450.

[7] W.S. Maclay, "The Adolf Meyer Lecture: A Mental Health Service," *The American Journal of Psychiatry* 120(1963): p.215.

[8] C.P. Seager, *Psychiatry for Nurses Social Workers and Occupational Therapists* (London: Heinemann Medical, 1968), p.212.

[9] Porter, *Greatest Benefit*, p.522.

[10] Ministry of Health, "A Hospital Plan for England and Wales," ed. Ministry of Health (London: HMSO, 1962). quoted in J.C. Little, "A Rational Plan for Integration of Psychiatric Services to an Urban Community," *Lancet* 2, no.7318 (1963): p.1159.

their further development is accepted Ministry of Health policy.'[11] A team of clinicians at King's College Hospital (KCH) note in 1966 that '[t]he Hospital Plan for England and Wales has made provision for a considerable increase in the number of short stay psychiatric units which will usually be attached to general hospitals... In recent years such units have been increasingly participating in the work of general hospitals and the Plan will presumably encourage this development.'[12] The Ministry of Health's controversial cutbacks on mental hospital spending[13] are largely underpinned in Britain *not* by the 'chlorpromazine revolution'[14] (although various drugs do come to occupy an influential role in psychiatric practice) but by an expansion in the sites of psychiatric provision – general practice, outpatient clinics etc. – without necessarily allocating them additional funding. The financial aspects of the *Hospital Plan* are well covered by Scull; as noted, focus upon financial provision tends to sustain the asylum-community binary.[15]

Psychiatric literature during the late 1950s and early 1960s is full of comment upon these local and specific developments. J. Hoenig and I.M. Crotty from Brighton comment in 1959 that '[u]nder the new Mental Health Act, the segregation of most psychiatric patients in special hospitals should gradually cease, and psychiatric treatment units will, we hope, be opened in general hospitals.'[16] C.P.B. Brook, a Senior Registrar at Guy's and Bexley Hospitals and David Stafford-Clark relate developments at New Cross General Hospital in 1961, mentioning their 'hope that there will be a substantial increase in psychiatric facilities in general hospitals.'[17] Fleminger and Mallett report from Guy's in 1962 that 'the practice of psychiatry in general hospitals is increasing'.[18] Joshua Bierer, consultant psychiatrist at the Runwell Hospital who establishes the UK's first psychiatric day hospital in 1946[19] claims that an 'important movement, especially in Great Britain, tends towards the opening of psychiatric wards in

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[11] Little, "Rational Plan," p.1159.

[12] P.K. Bridges, K.M. Koller, and T.K. Wheeler, "Psychiatric Referrals in a General Hospital," *Acta Psychiatrica Scandinavica* 42, no.2 (1966): p.171.

[13] Watkin notes that, '[t]he most controversial aspect... was probably the proposal to reduce the number of mental illness beds over a period of fifteen years from 3.3 / 1,000 population to 1.8 / 1,000'. B. Watkin, *Documents on Health and Social Services: 1834 to the Present Day* (London: Methuen, 1975), p.152.

[14] E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997).

[15] See Scull, *Decarceration*. This is not to deny that economic concerns are important in the political success of the *Plan*. (For the link between financial concerns and the asylum-community binary, see chapter three.)

[16] J. Hoenig and I.M. Crotty, "Psychiatric Inpatients in General Hospitals," *Lancet* 274, no.7094 (1959): p.122.

[17] C.P.B. Brook and D. Stafford-Clark, "Psychiatric Treatment in General Wards," *Lancet* 277, no.7187 (1961): p.1159.

[18] Fleminger and Mallett, "Psychiatric Referrals," p.183.

[19] C. Hassall, D. Gath, and K.W. Cross, "Psychiatric Day-Care in Birmingham," *British Journal of Preventive & Social Medicine* 26, no.2 (1972): p.112.

general hospitals.'[20] F.E. Kenyon, whose major work in the 1960s and 1970s concerns homosexuality, and also hypochondriasis,[21] and Michael Rutter, later eminent child psychiatrist,[22] open 'The Psychiatrist and the General Hospital' in 1963 with the statement that '[i]t is becoming widely accepted that an increasingly large number of psychiatric patients will have to be treated in general hospitals. The British Mental Health Act 1959 contributed to this trend by removing many of the legal distinctions between patients suffering from mental disorders and those who are physically ill.'[23] Maclay notes in 1963 that a 'topical subject is the psychiatric unit in the general hospital.'[24] His views on the desirability of this are clear: 'psychiatric outpatient work should be carried on in the general hospital even if there is a nearby mental hospital... this is vital if psychiatry is to be integrated with general medicine'.[25] Thus for Maclay, the desirability of these units goes *beyond* spatial advantages, and is far more about the administrative isolation to which mental medicine is still subject. (The DGH unit is not the only option, but is most relevant for 'attempted suicide'.[26])

Presumably because of their established links with mental disorder and their attachment to general hospitals, observation wards frequently become DGH units. Freeman notes that '[m]any of these [observation ward] facilities were later to become general hospital psychiatric units, particularly in Lancashire'.[27] This also happens in London; Dunkley and Lewis's short-stay treatment unit 'North Wing' is, they reveal, 'the name by which the former mental observation unit at St. Pancras is now known'.[28] Benady and Denham's 1963 report from the former observation ward at St Clement's Hospital argues that: 'psychiatric treatment has influenced the traditional role of the observation ward from diagnosis and disposal towards a short-stay treatment unit.'[29] They add that 'the change of policy from observation ward to early treatment unit had a more direct effect on the management and fate of the patients. No longer was the period of stay devoted only to making a tentative diagnosis and to sedate the patients until a mental hospital could be found.'[30] D.K. Henderson sums up the dynamics of this change in 1964: '[o]bservation wards for the treatment of acute emergencies will

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[20] J. Bierer, "Day Hospitals and Community Care," *Comprehensive Psychiatry* 4, no.6 (1963): p.381.

[21] F.E. Kenyon, "Studies in Female Homosexuality: Psychological Test Results," *Journal of Consulting and Clinical Psychology* 32, no.5 (1968); ———, "Hypochondriasis: A Clinical Study," *The British Journal of Psychiatry* 110, no.467 (1964).

[22] E.g. M.L. Rutter, *Maternal Deprivation Reassessed* (Harmondsworth: Penguin, 1972).

[23] F.E. Kenyon and M.L. Rutter, "The Psychiatrist and the General Hospital," *Comprehensive Psychiatry* 4, no.2 (1963): p.80.

[24] Maclay, "A Mental Health Service," p.215.

[25] Ibid.: p.211.

[26] See ———, "Appraisal of English Psychiatry," pp.102, 104.

[27] Freeman, "Psychiatry in the N.H.S.," p.3.

[28] Dunkley and Lewis, "North Wing," p.156. Dunkley also writes a brief postscript to the chapter dealing with the St Pancras ward in Stengel, Cook, and Kreeger, *Attempted Suicide*, p.95.

[29] Benady and Denham, "Early Treatment Unit," p.1569.

[30] Ibid.: p.1571.

continue, but they have also paved the way for the more highly specialised psychiatric clinics'.[31] From Brighton, R.P. Snaith and S. Jacobson concur in 1965: '[a]s there are to be short-term psychiatric treatment units in general hospitals, we believe that much of the experience gained in observation units is going to be of inestimable value.'[32]

The move from observation wards to DGH psychiatric units is another step in the integration of psychiatric and general medicine. This spatial integration refocuses attention upon the unhelpful stigma of segregated mental treatment. However, this focus on segregation undercuts the standing of observation wards, which go from embodying the integrationist and destigmatising spirit of the Mental Treatment Act (1930) to being overtaken by the 1959 Mental Health Act.[33] In other words, the observation ward is undercut as a preferred method of crossover between the separated therapeutic regimes of psychiatric and general medicine, largely due to its 'secure' and segregated nature, and also its enduring association with the Poor Law. As seen in chapter two, during the early years of the NHS, observation wards are seen as relatively progressive places where psychiatric treatment can take place outside of a mental hospital, relatively unstigmatized.

Carson and Kitching in Manchester comment on the stigma of 'mental wards' attached to general hospitals as early as 1949.[34] After the 1959 Act, such wards are even more out of step with the proliferation and integration of psychiatry through their differentiation between psychiatric and general patients. Stengel comments:

> 'In one English town at least, every case of attempted suicide is transferred to the psychiatric observation ward attached to the local general hospital; but in most other places this is impracticable, questionable on psychiatric grounds, and usually unnecessary. The practice is certainly out of keeping with the Mental Health Act 1959, which discourages discrimination against patients in the general hospital on the grounds that they present psychiatric problems.'[35]

E.W. Dunkley and Emmanuel Lewis also do not reflect fondly on observation wards. From the general hospital psychiatric unit 'North Wing' (the new name for the observation ward at St. Pancras General Hospital), they claim that '[t]he past association of psychiatric beds with

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[31] D.K. Henderson, *The Evolution of Psychiatry in Scotland* (Edinburgh: E. & S. Livingstone, 1964), p.116.
[32] Snaith and Jacobson, "Observation Ward," p.25.
[33] Norris is clear on the stigma of mental hospital treatment: 'The frontier separating the mentally sick from their presumptively mentally well relatives and friends is the gate of the mental hospital' Norris, *Mental Illness*, p.92.
[34] They note 'the stigma unfortunately still associated with a mental hospital or even with a mental ward.' Carson and Kitching, "Psychiatric Beds," pp.833, 835.
[35] Stengel, "Attempted Suicide: Management," p.234.

general hospitals can hardly be described as happy... for the most part they took the form of mental observation units in local-authority hospitals.'[36] Observation wards become reconstituted as 'treatment units', or are replaced simply by having psychiatric beds on general wards. Psychiatric scrutiny becomes more diverse and subtle in its integration with general hospital practice, but also less protected by institutionalised arrangements. The eclipse of the long-established observation ward by new DGH psychiatric treatment units is a substantial change, and provokes new conflict between therapeutic regimes.[37]

The range of clinical phenomena coming to psychiatrists' attention in a general hospital is different from those in a psychiatric hospital. There is awareness that this will change the kinds of clinical objects that emerge. Fleminger and Mallett argue in 1962 that '[r]egarding all our clinical findings, we believe that they are only representative of general hospital work. Substantially different figures may be expected from studies confined to particular departments of medicine or surgery which emphasize different psychiatric problems.'[38] Objects emerge as a result of clinical practice, something explicitly expressed by J.G. Macleod and Henry J. Walton (who co-authors *Alcoholism* (1965) with Neil Kessel) discussing 'Liaison between physicians and psychiatrists in a teaching hospital' (the Western General Hospital, Edinburgh) in 1969. They argue that '[t]he psychiatrists who had not previously worked in collaboration with physicians in a general hospital clarified for themselves that they were called on to examine and treat cases differing from the range presenting in psychiatric hospital practice; psychoneuroses with somatic manifestations were extremely common. Many patients had personality disorders of moderate severity, resulting from disturbances in the patient's parental family relationship.'[39] The imprecise boundary between psychological and physical illness, and focus upon social problems are again emphasised under these new arrangements.

Separated therapeutics, beds and referral

The 'physical' to 'psychological' transformations at the base of 'attempted suicide' are not enabled solely because these differing therapeutic regimes are applied under the aegis of the same hospital. The contrast between closer spatial integration, and sharper therapeutic conflicts that undercut it, is acute. Despite their potential to occur in the same place, psychiatry and general medicine remain separate in this period, and are still seen to involve

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[36] Dunkley and Lewis, "North Wing," p.156.

[37] Moya Woodside asks am important question in 1968, but provides no simple answer, merely stating difficulties of patient admission and management in a psychiatric emergency unit. Woodside, "Are Observation Wards Obsolete?"

[38] Fleminger and Mallett, "Psychiatric Referrals," p.189.

[39] J.G. Macleod and H.J. Walton, "Liaison between Physicians and Psychiatrists in a Teaching Hospital," *Lancet* 294, no.7624 (1969): pp.790-791.

dissimilar, sometimes incommensurable, therapeutic approaches and practices. The removal of legal constraints in 1959 and the Hospital Plan of 1962 result in mental and psychological medicine being increasingly provided in the same spaces, but the lack of administrative differences between them exacerbates friction between therapeutic approaches.

This is not a problem exclusive to the post-1959 period. R.W. Crocket at the Department of Psychiatry in Leeds wonders back in 1953 whether 'there is an inevitable conflict here, and that to combine the qualities required for first-class psychiatric care with those demanded by modern physical methods of investigation is an almost impossible achievement'.[40] There is abundant acknowledgement of therapeutic difference throughout the literature in the early 1960s, coupled with a sense that this difference is being lost or ignored in the headlong rush to proclaim psychic and physical ailments completely equal. An article in *The Medical Officer* in 1962 is anxious not to criticise the new Act, but offers 'the view that the mentally disordered – let us face it – require very special techniques and, with the best intentions in the world, cannot be treated entirely like the physically sick.'[41] A *Lancet* Lead Article puts it bluntly in 1962: '[t]he process of treatment is not the same in predominantly mental disorders as it is in predominantly physical ones; and this is something that must be made perfectly plain.'[42] Walter Maclay notes in 'After the Mental Health Act' that 'we must not lose sight of the basic truth that the nature of mental illness is different from the ordinary run of medical and surgical illness. The needs of psychiatric patients are different, too. Their needs are primarily emotional and only secondarily physical.'"[43] Kathleen Jones notes in 1963 that '[i]n a general hospital setting, the special needs of psychiatric patients may thus be overlooked... If a psychiatric unit is to function effectively in a general hospital setting, it requires a degree of autonomy rarely securable under present administrative arrangements.'[44]

Despite this enduring difference, there are increased opportunities for *access* to psychological scrutiny in general hospitals. Psychiatric access to general wards increases – indeed John Pickstone claims that 'the spreading of consultants from the regional medical capitals into ordinary 'peripheral' hospitals was one of the major aims and achievements of the early NHS... Here was the bridge by which psychiatry came to be seen in the same terms as other specialisms.'[45] However, whilst psychiatric units might be close by and even wards might be

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[40] R.W. Crocket, "In-Patient Care of General Hospital Psychiatric Patients," *British Medical Journal* 2, no.4828 (1953): p.123.

[41] J.S. Hoyle, "Informal Patients in Hospitals," *The Medical Officer* 107(1962): p.152.

[42] "Psychiatry in the General Hospital," *Lancet* 279, no.7239 (1962): p.1107.

[43] Maclay, "Appraisal of English Psychiatry," p.106.

[44] K. Jones, "The Role and Function of the Mental Hospital," in *Trends in the Mental Health Services*, ed. H.L. Freeman and W.A.J. Farndale (Oxford: Pergamon, 1963), p.68.

[45] Pickstone, "District General Hospitals," p.190.

'mixed', the basic unit of resources in a hospital, 'beds' is still something largely – though not exclusively – subject to one set of therapeutic and diagnostic practices. Hospitals are predominantly made up of mutually exclusive 'beds' for various specialisms, from general medical to geriatric, paediatric, psychiatric or surgical. Thus the transformations producing a 'psychological disturbance' from a 'physical injury' arriving at casualty and possibly also going for surgery or specialised resuscitation, requires practice that negotiates between these mutually exclusive spaces –'referral'. Separation endures, as the imagined 'walls of the asylum' give way to the resource politics of mutually exclusive 'beds', an exclusivity maintained upon ideas of practical therapeutic incompatibility. Nothing in the following section argues that somatic assessment or therapy is unnecessary. The argument is simply that because of the ways hospitals are set up with therapeutic approaches so separate, the priority of general, acute somatic medicine creates obstacles that need to be negotiated for a psychosocial 'attempted suicide' to emerge.

Separated Therapeutics: Negotiation and Psychiatric Scrutiny in DGHs

Studies from Brighton, Leicester and Sheffield, as well as several reports from an Accident Service at King's College Hospital (KCH) show how psychiatric scrutiny becomes reconfigured in general hospitals, and how somatic medicine remains the primary concern in these environments. The practice of 'referral' is the most important aspect of maintaining significant psychiatric scrutiny upon general hospital patients. However, varied practices are employed in DGHs to negotiate the therapeutic separation, practices that impact upon the psychosocial disturbance constructed around a presenting 'physical injury'. There is also a limited effort to elicit 'attempted suicide' from general practice. This is largely unsuccessful.

Brighton's Psychiatric Emergency (Observation) Unit (1965)

Snaith and Jacobson's 1965 article on 'The Observation Ward and the Psychiatric Emergency' from Brighton shows one of the ways in which short-stay treatment units develop out of observation wards. The Brighton Psychiatric Emergency (Observation) Unit remains similar to the separate wards of the interwar period, but still shows how referral is essential for cementing psychiatric attention upon 'attempted suicide'. The 1930s debate over the proper function of observation wards is not settled as these wards become the general hospital psychiatric units encouraged by the Ministry of Health. Snaith and Jacobson are aware of this history, and quote a *Lancet* editorial from 1936 which argues that the ideal observation ward should be 'at once the reception unit for acute and dangerous mental illness, the distributing and diagnostic centre, and the place of treatment of very transient conditions'.[46] They get right to the heart of the change in function, as well as the change in nomenclature, observing that

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[46] Quoted in Snaith and Jacobson, "Observation Ward," p.18.

'this editorial accurately predicted the development not so much of an observation ward, but of a short-stay treatment unit in a general hospital.'[47]

This unit (which has presumably been renamed from an 'observation ward' given the title of the article) benefits from 'close liaison with other services of the general hospital [and] facilities for the simpler procedures of general medical investigations and nursing.'[48] However, when more than 'simpler procedures' are necessary, the wider predominance of somatic therapeutics ensures that the ward relies upon transfer, mentioning 'attempted suicide' *specifically*: 'patients who have attempted suicide by narcotic poisoning or coal gas are only admitted from the general medical wards when fully restored to consciousness.'[49] They repeat, later on, that all such cases are 'admitted to the Emergency [Psychiatric] Unit only after the acute physical effects had been dealt with, either in casualty departments or medical wards.'[50] The therapeutic integration is clearly limited, and specifically for 'attempted suicide' cases the practice of referral is essential in order to overcome the administrative exclusivity of 'general' and 'psychiatric' beds. This is precisely what Kessel is talking about in 1962 when he claims that Ward 3 'serves as a psychiatric sorting and disposal unit for cases of attempted suicide far more effectively than the traditional English observation ward, which dares cater only for those who have not rendered themselves unconscious or hurt as a result of their actions.'[51]

The crucial link between referral practices and certain kinds of attention to 'attempted suicide' is shown by the observation that:

> '[t]he cases admitted from casualty departments were not seen by psychiatrists before referral, and only 10 per cent. were seen by psychiatrists in the general hospital wards before transfer to the Emergency Unit. However, a comprehensive review of each suicidal attempt was made by a consultant psychiatrist after admission.'[52]

Very limited psychiatric scrutiny is thus available on general hospital wards. Although there appears to be no psychiatric *scrutiny* in casualty, HM(61)94 only asks for referral, which is provided by the psychiatric Emergency Unit. More importantly, this study shows that consistent psychiatric scrutiny for the vast majority of patients relies upon the existence of such a unit, with consultant psychiatrists on the staff. There is also the possibility for follow-up

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[47] Ibid.
[48] Ibid.: p.19.
[49] Ibid.: pp.19-20.
[50] Ibid.: p.23.
[51] Kessel, "Attempted Suicide," p.314.
[52] Snaith and Jacobson, "Observation Ward," p.24.

concerning 'the psychiatric social worker or the mental welfare officer attached to the unit.'[53] Separate therapeutic regimes must be negotiated, and this is emphasised, with the authors noting '[t]he value of the unit to the general medical facilities in the area… Of the 33 patients accepted from general hospital wards, 22 were recovering from suicidal attempts and 7 were suffering from acute delirious conditions; the disturbance caused by both these groups of patients in a general hospital ward can be formidable.'[54] Thus two thirds of the referrals from general wards (the breakdown of the 75 admitted from casualty is not provided) are 'attempted suicides', being brought under renewed psychiatric scrutiny. A solution to a management / disturbance problem on general wards brings to light a clinical object of 'attempted suicide'.

Parkin and Stengel in Sheffield (1965)

One of Erwin Stengel's first major research projects at Sheffield (having been awarded the Chair in Psychiatry in 1957) is a collaboration with Dorothy Parkin published in 1965. The aim is to combine 'attempted suicide' numbers from three administrative levels (general hospitals, mental hospitals and general practice) into one composite 'incidence' statistic.[55] This study is based upon records rather than clinical encounters, but referral practices negotiating separate therapeutic regimes are still vital to the production of these records.

The general hospital group is based upon record scrutiny at three Sheffield General Hospitals; these records come from a number of different sources. However, 'attempted suicide' does not appear on casualty records. Although Stengel and Parkin claim that 'as a rule it was easy to pick out the suicidal attempts from the records' and 'suicidal attempts were almost invariably recognised as such by the casualty officers,'[56] it is admitted that '[a]ttempted suicide is not a diagnosis and therefore does not appear in the diagnostic index of hospital records'.[57] Instead, they use the following *somatic* categories recorded in casualty which 'served as indications for closer study of the casualty to which it refers : (a) no diagnosis, (b) collapse, (c) coma, (d) head injury, (e) laceration of throat and wrist, (f) stab wound, (g) poisonings of all kinds.'[58] This shows the therapeutic focus of casualty and the importance of the somatic which is modified and transformed by 'closer study' from Stengel and Parkin. For those cases not admitted as inpatients, a 'psychiatrist is always on call, and patients not admitted to a ward are seen by

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[53] Ibid.
[54] Ibid.: p.25.
[55] They also include a fourth group 'people who made a suicidal attempt without a doctor being called in. The size of [this group] is not ascertainable… probably small but not negligible.' D. Parkin and E. Stengel, "Incidence of Suicidal Attempts in an Urban Community," *British Medical Journal* 2, no.5454 (1965): p.133.
[56] Ibid.
[57] Ibid.
[58] Ibid.

him before being sent home.'[59] The somatic therapeutics of casualty are thus further negotiated by referral to an on-call psychiatric consultant.

Patients that *are* admitted end up at the psychiatric departments of these hospitals in three ways. They claim that '[t]he majority of these cases seen in the casualty departments were admitted to medical and a few to surgical wards of the three general hospitals... Some were admitted to the *psychiatric departments* of these hospitals direct from the casualty departments.'[60] Thus 'attempted suicide' is formed in a psychiatric department through referral either from medical wards or surgical wards, or admitted directly from casualty. There is no doubt about the predominance of the somatic in these referrals, as some patients are only 'transferred to these [psychiatric] departments after the state of medical or surgical emergency had subsided.'[61] Thus there are a number of ways through which these cases come to be labelled as 'attempted suicide'. There is 'close study' of certain somatic categories on casualty records, there is an on-call psychiatrist for those not admitted as inpatients, and there is referral to the psychiatric inpatient department once any medical or surgical 'emergency' has been dealt with. In all these ways, somatic is transformed into psychological concern, using referral to negotiate the predominance and separateness of somatic therapeutics.

They also mention a practice that does not require retrospective scrutiny (however 'easy' it may be to construct a series of 'attempted suicides' from records). They note that 'in the psychiatric department of the Royal Infirmary a simple questionary is filled in for every new inpatient and outpatient. One group of questions refers to suicidal attempts.'[62] Thus, with a tick in the right box, a running record of 'attempted suicide' is kept; put another way, a bureaucratic space is cleared, into which, at the stroke of a pen, cases arriving at certain departments of certain hospitals become conceptualised as 'suicidal attempts', rendered epidemiological and countable. Bearing in mind both Kessel and Stengel's points that '[a]ttempted suicide is neither a diagnosis nor a description of behaviour'[63] and will not show up in diagnostic records, such recording processes must be created, so that it might be inscribed, tabulated and transformed into a credible object of research.

The negotiations in the general practice group are different. Parkin and Stengel are open about these difficulties, noting that '[t]he size of the third group – that is, of those seen by general practitioners first – can be established only by a special survey.'[64] It is important that these are

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[59] Ibid.: p.134.
[60] Ibid. Original emphasis.
[61] Ibid.
[62] Ibid.
[63] Kessel, McCulloch, and Simpson, "Psychiatric Service," p.987.
[64] Parkin and Stengel, "Urban Community," p.133.

questionnaires designed and produced by psychiatrists, in order to render countable and intervene upon the very objects that they are in the process of creating, by sending them to practitioners. This GP input is also carefully managed. The opening question is relatively straightforward: '[h]ow many of your patients made suicidal attempts during the last year?'[65] However, the second question 'How many patients did you *suspect* of having made a suicidal attempt?'[66] in Parkin and Stengel's words 'needs some explanation.'[67] They ask this because 'doctors not versed in psychiatry and unfamiliar with the suicide problem tend to classify among suicidal attempts only those patients who admit suicidal intention.'[68] The GP is compared unfavourably with the 'experienced psychiatrist [who], when seeing such patients in hospital does not find it difficult to elicit suicidal intention from them, or at least the feeling that "they did not care whether they lived or died." Many, perhaps most, suicidal attempts are carried out in such a mood'.[69]

This is an intervention designed to make the arena of general practice and that of the general hospital *equivalent*. It does this by using 'suspicion' as a practical approximation for 'psychiatric expertise'. This is something of an heroic effort at maintaining the 'cry for help' with a stand-in for psychiatric scrutiny. Parkin and Stengel are perhaps aware of the stretch that they are asking their readers to make, as they add that a 'discussion with a group of general practitioners about the inquiry suggested that the inclusion of this question served the intended purpose.'[70] So this shows that whilst psychiatric expertise is not strictly essential to the production and maintenance of the 'cry for help', some significant intellectual labour to bring about an approximation is necessary.[71] This again shows the diverse ways in which various physical injuries from a number of sites are brought under psychiatric scrutiny.

The 'blind spot' of general practice

It is not just the broad separate therapeutics of psyche and soma that must be negotiated in order for a psychosocial 'attempted suicide' to emerge. The necessity for 'attempted suicide' to be subject to the sub-specialism of *acute* somatic care is also important. Although twentieth-century general practice medicine and interpersonally-focused psychology share 'a

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[65] Ibid.: p.137.
[66] Ibid. Original emphasis.
[67] Ibid.: p.134.
[68] Ibid.
[69] Ibid.
[70] Ibid.
[71] GPs are involved with Stengel et al.'s 1958 study, in the Dulwich General Hospital group (Group V), where '[w]ith 33 patients... a medical practitioner had been involved in the admission. With 26... no general practitioner had intervened, and with 17 patients... it was uncertain whether this was so'. The Sheffield study is different; practitioners are being utilised to provide the object without the necessity for a general hospital. Stengel, Cook, and Kreeger, *Attempted Suicide*, p.96.

mutually reinforcing agenda',[72] the present 'attempted suicide' object is unsuitable for general practice studies due to the 'acute' or 'emergency' status of many 'attempted suicides.' This creates what might be called an administrative 'blind spot', acknowledged by Watts in 1966, when he comments that although '[t]he family doctor with psychiatric training may be able to deal with some cases [of 'attempted suicide']' what happens in practice is that 'most of the cases reported to us in general practice are seen at the time of the incident and need to be admitted to hospital for emergency measures, so they pass out of our care.'[73] (A related blind spot is acknowledged in *Psychiatric Illness in General Practice*.[74]) Previous chapters have shown how important sustained, intensive scrutiny is to the fabrication of a 'social setting' around the 'attempted suicide'. However, it is precisely these patients who miss out on such scrutiny in general practice, as they are referred through the emergency department to the psychiatric outpatient department of the general hospital to which they are admitted.

Whilst there are some studies that mention attempted suicide in general practice,[75] GPs are largely shut out of hospital medicine, regarded as a 'menace' in this period.[76] GPs, like A&E, are more like 'finger posts'[77] in the case of 'attempted suicide', and even share with the 'administrative machinery' of Casualty, a crude stereotype. Like Lowden's young girl who has 'misbehaved and missed her period' presenting at casualty,[78] Watts and Watts note in *Psychiatry in General Practice* (1952) that '[the hysteric] is ready to provoke a stir by threatening suicide and may even attempt to do it in a half hearted way.'[79] It should be noted that when E.W. Anderson's 'Psychiatric Emergencies in General Practice' (1952) states that '[t]he suicidal attempt is no doubt the prime emergency of practice' this is not because of the interpersonal expertise and social knowledge of the GP, it is because 'the practitioner may be called upon suddenly to administer first aid to such a patient.'[80]

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[72] R. Hayward, *Self Cures: Psychology and Medicine in Modern Britain [Draft]* (2012). See also Henderson, *Evolution of Psychiatry*, p.266; C.A.H. Watts and B.M. Watts, *Psychiatry in General Practice* (London: Churchill, 1952), p.12.

[73] Watts, *Depressive Disorders*, p.127.

[74] GPs are said to be in danger of missing 'cases of attempted suicide admitted direct to general hospitals.' Shepherd et al., *Psychiatric Illness in General Practice*, p.40.

[75] Watts, *Depressive Disorders*. See also C.A.H. Watts, E.C. Cawte, and E.V. Kuenssberg, "Survey of Mental Illness in General Practice," *British Medical Journal* 2, no.5421 (1964).

[76] F. Honigsbaum, *The Division in British Medicine: A History of the Separation of General Practice from Hospital Care 1911-1968* (London: Jessica Kingsley, 1979), p.299. See also A. Cartwright, *Patients and Their Doctors : A Study of General Practice* (London: Routledge & Kegan Paul, 1967), p.122.

[77] 'there is a danger that we [GPs] may become finger posts directing our patients to the most appropriate specialist.' Watts and Watts, *Psychiatry in General Practice*, p.13.

[78] See chapter two.

[79] Watts and Watts, *Psychiatry in General Practice*, p.151.

[80] E.W. Anderson, "Psychiatric Emergencies in General Practice," *The Practitioner* 168, no.1006 (1952): p.363.

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'Attempted Suicide in Leicester' (1966)

Two medical clinicians (G.G. Ellis and R.L. Hewer) and a psychiatric registrar (K.A. Comish) publish a study of 'attempted suicide' carried out at Leicester's Royal Infirmary, opening with the statement that '[a]ttempted suicide should be considered as an act in its own right, and not merely as an unsuccessful suicide, according to Stengel'.[81] Their study is prompted by 'a general impression among physicians and psychiatrists in Leicester that the number of attempted suicides admitted to the Royal Infirmary was large and increasing.'[82] (They also mention '[g]eneral impressions that the number of attempts throughout the country is rising.'[83]) They use a 'stereotyped questionnaire' to interview all patients *admitted* to the Royal Infirmary over a six-month period in 1964.[84]

Separated therapeutics emerge again because the 'majority of attempted suicides seen in casualty are admitted to medical beds. Comatose patients are treated in an intensive therapy ward until conscious.'[85] Thus referral comes to the fore once more. They also note that '[t]he Ministry of Health hospital circular (HM.61.94) issued shortly after the 1961 Act asked that all cases of attempted suicide brought to a general hospital should receive psychiatric investigation before discharge.'[86] Whilst they claim that '[i]t is an accepted practice at Leicester Royal Infirmary that all cases of attempted suicide are referred to a psychiatrist,'[87] they also relate that there are thirty-eight 'admissions who were not seen by a psychiatrist'[88] in addition to the twenty-eight patients who are not admitted to the wards and not included in the survey, simply 'sent home from casualty.'[89] Thus twenty-five percent of those considered 'attempted suicides' are not brought under psychiatric scrutiny. It is not stated why the thirty-eight admitted patients fail to receive psychiatric scrutiny, but for the twenty-eight sent home, it is because they 'were judged to have damaged themselves insufficiently to require admission to a medical or surgical ward.'[90] Thus psychiatric scrutiny is sometimes *dependent* upon somatic injury, at the same time as referral is necessary to transform that injury.

Of those that are investigated psychiatrically, a process is described that begins to fabricate a social constellation around the attempt: 'in searching for a precipitating cause, patients were asked about worries, particularly financial problems, recent and long-standing emotional

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[81] G.G. Ellis, K.A. Comish, and R.L. Hewer, "Attempted Suicide in Leicester," *Practitioner* 196(1966): p.557.
[82] Ibid.
[83] Ibid.
[84] Ibid.: p.558.
[85] Ibid.: p.557.
[86] Ibid.: p.560.
[87] Ibid.
[88] Ibid.
[89] Ibid.
[90] Ibid.: p.559.

problems, and chronic ill-health'.[91] They admit that '[i]t was rarely possible for the psychiatrist to interview relatives'[92] but this is presumably considered desirable in these cases, but impractical. This suggests that without a dedicated PSW for this practice, psychiatrists rarely have time for such a detailed social data collection.

A further problem is the lack of a hospital psychiatric unit meaning that 'psychiatrists have to be informed and awaited. Their interviews have to be brief, and instant decisions about the need for further treatment have to be made. Those given a psychiatric outpatient appointment may be lost sight of.'[93] Nevertheless, this study brings to attention a 'disproportionately large group was that of 15- to 24-year-old females. Forty-four girls were under 21.'[94] A gendered, stereotyped, interpersonal narrative emerges:

> '[t]hese girls [females under 21] form one third of the females and one fifth of the total cases seen. A recent emotional problem (especially with boy-friend or parents) was the precipitating cause in 80 per cent. and only 24 (55 per cent.) admitted to feeling depressed before the attempt.'[95]

They also conclude that '[i]nterpersonal stress was the precipitating factor in 41 per cent'[96] of the whole sample, but '[i]nterpersonal difficulties were major precipitating causes, especially among females under 21.'[97] The confluence of 'interpersonal stress' and a feminised gender stereotype is absolutely crucial in this psychosocial object. 'Stress' does not only link 'the social' to the pathological behaviour of 'attempted suicide', it produces a significantly gendered archetype, as seen in chapter four. Separated therapeutics are negotiated by referral at some considerable effort, and various practices and approaches bring to relevance a disturbed, significantly gendered interpersonal situation.

King's College Hospital Accident Service

There are six reports from King's College Hospital (KCH) between 1966-1969 that are based on, or give significant mention to 'attempted suicide'. KCH has extensive links to the Maudsley, and not only geographical ones.[98] Following the founding of the Maudsley in 1923 '[f]ormal links were rapidly established with the adjacent King's College Hospital: Mapother lectured at its medical school, saw patients there and later was given access to a 35-bed ward.'[99] This

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[91] Ibid.
[92] Ibid.: p.560.
[93] Ibid.
[94] Ibid.: p.558.
[95] Ibid.: p.561.
[96] Ibid.: p.560.
[97] Ibid.: p.561.
[98] They are across the road from each other in Camberwell, London.
[99] Jones, Rahman, and Woolven, "Design and Strategic Direction," p.358.

ward, leased in 1932, and known as the 'Maudsley Annexe'[100] has the distinction of being '[t]he first teaching hospital [psychiatric] unit, the only one before World War II… [it was] allocated to Professor Mapother and staffed by the Maudsley Hospital.'[101]

P.K. Bridges and K.M. Koller (Psychiatric Registrars) and T.K. Wheeler (Senior House Officer) publish an account of 'Psychiatric Referrals in a General Hospital'. This shows the practices and arrangements put in place more than a quarter of a century after the closure of the 'Annexe' in 1939 that attempt the integration and reconfiguration of mental healthcare. This has consequences for the very possibility of 'attempted suicide' as they refer not only to studies of psychiatric morbidity in these short-stay units, but also to 'the special problem of the management of cases of attempted suicide in general hospitals'.[102] They later comment that a 'large part of the work in this department is concerned with patients who have attempted suicide'.[103] At another interface between psychiatric therapeutics and general hospitals, 'attempted suicide' comes to psychiatric attention. This is partially attributed to a 'regional accident service that has been developing in recent years which may partly account for the rising intake of cases of attempted suicide.'[104] It is later argued, however, in a shift from practices to 'social attitudes', that '[f]ollowing recent changes in social attitudes, suicide attempts appear to be increasing and it is likely that more of these patients now come to hospital.'[105] There is a rather opaque reference to 'increasing medical awareness of the potential significance of the suicidal attempt' which entails that 'virtually all cases are referred to a psychiatrist.'[106]

Given the focus upon 'attempted suicide' in that report of psychiatric referrals, it is unsurprising that Bridges and Koller use the same arrangement to analyse this clinical group separately, using a control group for comparison. They demonstrate again in 'Attempted Suicide: A Comparative Study', their reliance upon the 'accident service'.[107] The accident service is not specifically intended to bring 'attempted suicide' in to view, or under psychiatric scrutiny, but because of this arrangement, there is a new potential field for clinical and research objects. In both articles this field is constituted through referral after somatic assessment: '[v]irtually all cases of attempted suicide admitted to the hospital are referred for a psychiatric opinion, and patients are usually first seen for this purpose soon after medical

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[100] Ibid.: p.369.
[101] Mayou, "General Hospital Psychiatry," p.768.
[102] Bridges, Koller, and Wheeler, "Psychiatric Referrals," p.171.
[103] Ibid.: p.180.
[104] Ibid.: p.178.
[105] Ibid.: p.180.
[106] Ibid.
[107] P.K. Bridges and K.M. Koller, "Attempted Suicide. A Comparative Study," *Comprehensive Psychiatry* 7, no.4 (1966): p.240.

recovery or shortly after admission if medical treatment is not indicated.'[108] More intellectual work is required, as 'attempted suicide' is even then not a self-evident 'object'. They relate that 'in the case of six patients it was decided after further investigation that there had been no intent deliberately to cause self-injury.'[109] Thus more (intellectual) labour – 'further investigation' – is needed to produce and maintain this object, around 'intent'. A year later, in 1967, Bridges' remarks (from University College Hospital in North London) show the necessity of referral, and the difficulty of establishing psychiatric scrutiny in accident departments. He argues that 'psychiatry has insufficiently been accepted into the general hospital and, therefore, Casualty Departments, where the need can be most acute, usually have considerable difficulty in obtaining psychiatric advice when it is required.'[110] Further, '[c]asualty officers understandably may lack confidence in dealing with psychiatric cases'.[111]

H. Steven Greer is interested in this phenomenon in his early career, and one of the four signatories on the letter to the *British Journal of Psychiatry* that first proposes the term 'parasuicide' in 1969.[112] In 1966, when Lecturer in Psychological Medicine at KCH Medical School, he reports on 'attempted suicide' with Koller featuring again, and also J.C. Gunn (a psychiatric registrar based at the Maudsley). They include Dulwich Hospital as part of KCH: '[a]ll patients admitted to King's College Hospital (including Dulwich Hospital) for suicidal attempts between 1 March and 1 September 1965 were included in the study'.[113] The inclusion of Dulwich might be due to the fact that – as F.E. Kenyon and Michael Rutter report in 1963 – '[s]ince 1957 the full-time services of an experienced Registrar from the Bethlem Royal and Maudsley Hospital have been available' at Dulwich,[114] bringing consistent psychological scrutiny to a general hospital.[115]

They again mention the 'accident service', coupled with referral as key: '[i]n this study we have taken advantage of an accident service provided by King's College Hospital. Within a defined area of South-east London all patients using the emergency ambulance service are brought to the casualty department. Any patient who has made a suicidal attempt, however slight the medical danger, is admitted and referred for psychiatric opinion.'[116] This explicit mention of

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[108] Ibid.

[109] Ibid.

[110] P.K. Bridges, "Psychiatric Emergencies," *Postgraduate Medical Journal* 43, no.503 (1967): p.599.

[111] Ibid.

[112] Kreitman et al., "Parasuicide."

[113] S. Greer, J.C. Gunn, and K.M. Koller, "Aetiological Factors in Attempted Suicide," *British Medical Journal* 2, no.5526 (1966): p.1352.

[114] Kenyon and Rutter, "Psychiatrist," p.80.

[115] Although Kenyon and Rutter's article states that it is from the Maudsley, Mayou's work implies that the South-East London Hospital providing the clinical base is Dulwich. Mayou, "General Hospital Psychiatry," p.774.

[116] Greer, Gunn, and Koller, "Aetiological Factors," p.1352.

'medical danger' suggests the lowering of a threshold normally required for admission to the casualty department, and thus this arrangement helps to constitute a new field, at a casualty department, in which 'gestural suicidal attempts' are more likely to become objects of scrutiny. It also functions to downplay the significance of somatic assessments, so that all patients come under psychiatric scrutiny, not just those coded (by physicians or surgeons) as seriously injured. The fact that 'medical danger' is self-consciously disregarded as a criterion for admission shows how potentially 'gestural' injuries might only become visible to psychiatrists at general hospitals because they are *sought*.

John Bowlby's ideas of childhood psychopathology re-emerge here,[117] possibly influenced by Michael Rutter's engagement with Bowlby's ideas at the MRC Social Psychiatry Research Unit at the IoP.[118] Greer and colleagues explicitly question these 'attempted suicides' about childhood parental loss ('broken parental homes') and any 'recent disruption of close interpersonal relations'.[119] This is done through standardised practices, designed to result in a coherent object of 'attempted suicide': '[a] protocol was designed for recording relevant data about each patient. Information was obtained from structured interviews with patients, and in some cases relatives were also seen.'[120] Through this they are able to claim that 'parental loss contributes to attempted suicide' as it 'predispose[s] to disruption of interpersonal relationships, and... childhood experience may make individuals abnormally vulnerable to the loss of a loved person later in life, thus precipitating suicidal reactions.'[121] This 'predisposition' (based on faulty childhood development) is a key conceptual plank enabling past or present social environments to *cause* 'attempted suicide'. Increasingly, these KCH studies use an accident service, accessible to psychological clinicians through the Department of Psychiatry, which enables people admitted to that accident service – where the 'accident' is physical, if potentially slight – to be placed within a psychological nexus of childhood experience and interpersonal relationships. The conceptual apparatus of Bowlby, models of psychological 'development' and pathological reactions to 'stress' are by no means less important than administrative and practical arrangements. Indeed, 'conceptual' and 'practical' labours do not occur independently of each other.

In another study undertaken by Greer and Gunn only, patients from 'intact homes' and those who had suffered 'parental loss' are compared. The previous study is said to 'provide evidence

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[117] See discussions of Bowlby, development and 'stress' in chapters two and four.
[118] Rutter's fullest engagement is Rutter, *Maternal Deprivation*.
[119] Greer, Gunn, and Koller, "Aetiological Factors," p.1354.
[120] Ibid.: p.1352.
[121] Ibid.: pp.1354-1355.

for a relation between attempted suicide and parental loss.'[122] However, because 'this childhood experience occurred in only 49% of suicidal patients' this second study is undertaken in order to gain 'information about predisposing factors in those patients who have not suffered parental loss, and to determine, if possible, whether the circumstances associated with suicidal behaviour differ among patients from broken and intact homes.'[123] The most significant difference found is that 'attempted suicide' from those who have suffered 'parental loss' are considered to be triggered more often by 'disruption of interpersonal relations'.[124] They elaborate that '[t]his situation was judged to have occurred where interpersonal conflict had led to an actual break or the threat of imminent separation in a close relationship within six months of admission to hospital. Such experiences consisted of broken love-affairs or marriages in every case except one'.[125] Using the accident service, a system of referral, a lowered somatic threshold, a protocol for a structured interview and finally, a 'control group' of patients from 'intact parental homes', the immediate interpersonal environment of an 'attempted suicide' can be related most strongly to an interpersonal conflict that is ambiguously associated with a childhood environment.

Unsurprisingly, given his previous work with Stengel, Kreeger's work on 'attempted suicide' at KCH is specifically focused upon these kinds of interpersonal disturbances. His approach is based on the principle that '[i]n every patient an attempt should be made to identify the nature of the appeal, whether this is for amelioration of environmental stress or for protection against overwhelming internal conflict.'[126] He further claims that '[a]n attempt to understand the suicidal reaction in the context of the patient's life situation should always be made.'[127] He adds that a joint interview is helpful in this process, bringing the relatives and social constellation to prominence: '[a] joint interview with the patient and relative may reveal aspects of the relationship not otherwise apparent, as depressed patients are often unable to express criticism or even perceive fault because of their guilt and self-reproach.'[128]

Finally from KCH, J.P. Watson (based at St. Francis Hospital) also uses the Accident Service in his 'case-record survey'. For Watson, between 47% and 53% of all his 'psychiatric series' cases

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[122] S. Greer and J.C. Gunn, "Attempted Suicides from Intact and Broken Parental Homes," *British Medical Journal* 2, no.5526 (1966): p.1355.

[123] Ibid.

[124] Ibid.: p.1356.

[125] Ibid.

[126] Kreeger, "Initial Assessment," p.93.

[127] Ibid.: p.94.

[128] Ibid.

studied 'presented with a suicidal problem'.[129] The way in which he constructs this series, and the negotiation that he puts in place to allow attempted suicide to figure, clearly shows the allowances that have to be made for such an object to emerge in the general hospital environment. He relates that 'an episode was deemed "psychiatric" if the patient came to hospital with a problem relevant to psychiatry and did not require medical, surgical, gynaecological or dental treatment'.[130] Thus 'psychiatry' is defined, in practice, largely by the absence of other specialist attention. This is eloquent testimony to the extent to which the therapeutics of psychiatry are separated from other specialisms. However, in psychiatry, one exception is made. The above definition comes with the significant qualification: 'unless he had deliberately poisoned or injured himself.'[131] So psychiatric problems are normally accessed if there is no other claim on a patient in the general hospital environment. The exception is the self-poisoned or self-injured patient, where it is accepted that these patients might be treated 'medically' or 'surgically' first. This shows once again how 'attempted suicide' must in this period emerge through practices that *negotiate* the separated therapeutics of the district general hospital, in casualty departments.

'The Natural History of Attempted Suicide in Bristol' (1969)

John Roberts and Douglas Hooper are based at Bristol University's Department of Mental Health, and they decide to survey a 10-month period of admission to the United Bristol Hospitals. They make the priority of 'physical treatment' and the necessity of referral for psychiatric scrutiny explicit. Their study is based upon 'a psychiatric consultant service... in which one of us [Roberts] was responsible for seeing all patients in this category *at the request of the admitting service*'.[132] Their sample is a study of 105 patients admitted between August 1964 and May 1965. They are clear that it 'is of importance to reiterate that the patients under discussion are *referred* (that is selected) cases'.[133] Thus referral is essential for psychiatric attention on general hospital patients. Again, this is due to the continuing precedence of general medical over psychiatric therapeutics. At first, they concede definitional authority to somatic medicine, stating that '[f]or the present purposes it was decided to use the medical definition of suicidal attempt which was applied by the physician or surgeon admitting the patient.'[134] This is something with which Kessel and colleagues are specifically concerned in

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[129] 47% have 'suicidal problems', but as 'suicide was more or less relevant in 53% of the psychiatric episodes.' J.P. Watson, "Psychiatric Problems in Accident Departments," *Lancet* 293, no.7600 (1969): p.877.

[130] Ibid.

[131] Ibid.

[132] J. Roberts and D. Hooper, "The Natural History of Attempted Suicide in Bristol," *British Journal of Medical Psychology* 42, no.4 (1969): p.305. Emphasis added.

[133] Ibid.: p.310. Original emphasis.

[134] Ibid.: p.305.

1963. They argue that one of the problems in assessing the ambiguous 'attempted suicide' is that it is *obscured* through the practicalities of referral through the motivations of the referring physicians. It is perhaps more precise to say that the shape and characteristics of this 'attempted suicide' is substantially constituted by these motivations. Kessel's claim is that:

> '[t]here is a continuum running from an individual doubling the prescribed dose of his customary sleeping-pills to the deliberate production of prolonged unconsciousness or death… Somewhere along this continuum, too, overdosage becomes arbitrarily equated with attempted suicide. Most psychiatrists who have written about attempted suicide have taken their case material for granted. It has consisted of those patients who have been referred to them following a self-destructive act. This referral has been decided by a general physician or surgeon, who tends to select three groups of patients: those who patently remain suicidal, those who have seriously endangered their lives, and those for whom they want help with disposal.'[135]

Rather than debating whether this is a complete picture or not (and it is certainly a hypothetical one, as this article is *not* about Ward 3 at this point) it is useful to see it as a particular object, produced under particular constraints, in context. Roberts and Hooper tackle this problem in an innovative manner, as they suspect 'that not all cases were being referred for psychiatric consultation'.[136] In an attempt to rectify this, 'the records of the United Bristol Hospitals were analysed for all patients classified in the International Classification of Diseases under head E970-979 which includes most suicidal patients.'[137] This cross-referencing leads them to claim that 'during the period of the study only 46.5 per cent of the men and 60 per cent of the women were actually referred.'[138] Again, referral is a fraught business, and they add that the 'discrepancies are particularly marked for the older patients'. They claim that only 37.5% of men and 39% of women over the age of 45, coded as having 'self-inflicted injury' under ICD-7, are referred to psychiatrists. Their cross-referencing also establishes that over half the men but only 40% of women escape psychiatric scrutiny under the referral system. The emergence of an 'attempted suicide' phenomenon populated predominantly by young females is thus unsurprising.[139] Patterns of referral between psychiatry and casualty are not only crucial to the existence of this phenomenon, but can be related to its specific characteristics as well.

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[135] Kessel, McCulloch, and Simpson, "Psychiatric Service," pp.986-987.
[136] Roberts and Hooper, "Natural History," p.307.
[137] Ibid.
[138] Ibid.
[139] Ibid.

So despite the best efforts of the *Hospital Plan*, therapeutic approaches remain significantly unmixed in this period. A number of different tactics, arrangements and procedures are necessary for 'attempted suicide' to emerge. Some, such as Parkin and Stengel's study are *designed to elicit* an 'attempted suicide' object, whilst still relying upon much wider systems of referral. Other, such as the KCH Accident Service bring an object named 'attempted suicide' to attention that is no less the product of human administrative intervention. It is further transformed and embedded, as clinicians modify and embellish established hospital practices such as lowering the somatic injury threshold for psychiatric referral, or cross-referencing referral rates with ICD classifications or making exceptions with other specialists. Referral stands at the centre of all these processes, right at the core of 'attempted suicide as a cry for help', the key enabler for the transformation of a presented physical injury into a psychosocial disturbance. However, there are noted problems around the practice of referral, and one of them is a conflict over resources between general hospital psychiatrists and other established specialisms such as surgery. These conflicts form a useful window on how psychological, behavioural, clinical objects become what might be termed 'fully established' and self-reinforcing.

Social spaces embedded and established through the politics of therapeutic conflict

The final part of this thesis looks at how therapeutic *conflict* (rather than simply *separated* therapeutics) provides extra impetus for the establishment and projection of a 'social constellation' around a hospital presentation of 'attempted suicide'. Due to pressure (perceived by psychiatrists) for a quick discharge from a 'general medical bed' after somatic injuries are dealt with, the 'social constellation' is increasingly invoked as a reason to keep a patient admitted. Thus the 'social constellation' shifts from being produced (laboriously) around an 'attempted suicide' through involved psychiatric scrutiny, to being increasingly presumed, and deployed tactically in order to promote and sustain such scrutiny. The 'social constellation' gets split from the practices that produce it, and inverted, that is, placed before the 'attempted suicide', being productive *of it*. This process underpins the increasingly commonsense view that 'interpersonal stress' or 'psychopathological domestic environments' *cause* attempted suicide. It is another example of how practical and contextual conflicts impact upon clinical, epidemiological, psychiatric, supposedly self-evident objects. This section proceeds with examples from the hospitals just surveyed, as well as from Kessel in Edinburgh, who spends much time detailing conflicts that he imagines in other general hospitals in order to show how Ward 3 is different.

A number of conflicts over admission, management and discharge occur between psychiatric and general medical doctors.[140] This is most explicit in Irving Kreeger's paper on the assessment of suicidal risk. He reports that a 'hazard arises when patients are seen in general hospitals after making suicidal attempts. There is usually considerable pressure for quick discharge ... from physicians, who resent their beds being blocked... there is a need to guard against the tendency to placate [the physicians].'[141] He places dramatic emphasis on the '[t]he irrevocable consequences of mistaken judgment [that] colour every aspect of our handling of the suicidal patient, but in none more so than in our first decision, which is whether to treat a new patient as an inpatient or an outpatient.'[142] This is a clear intervention in a conflict over scarce resources (beds), the basis for this 'attempted suicide' object.

One of Kreeger's key arguments concerns the 'social environment' that he, Stengel and Cook work so hard to establish during the 1950s. However, this time it is deployed as a potential danger to the patient unthinkingly discharged. He emphasises that the 'patient can be at hazard for a number of reasons' including the 'overprotective, denying relative', the 'frightened, submissive relative who is unable to support the patient' and '[r]elatives who may be the precipitating cause of the trouble.'[143] Not only is suicidal risk emphasised in order to gain more time to decide ('our first loyalty is to our patients and they should be discharged only when we feel able to make an informed decision'[144]) but the social environment is deployed as hazardous and dangerous. Whilst this 'social environment' may also push towards inpatient admission (to a psychiatric bed), it is also part of an explicit and concerted strategy against general physicians' pressure to discharge. Ellis and colleagues in Leicester seem to describe the very situation that Kreeger warns against when they relate that 'the average length of stay was three days. Because of the demand for beds this was the shortest stay compatible with full medical treatment and generally too short for full psychiatric assessment.'[145]

Bridges, Koller and Wheeler also note serious pressure on resources, but a more amicable resolution. Perhaps because at KCH there is such 'an established psychiatric department'[146] (linked to the Maudsley), they are pleased to report that '[c]onsiderable co-operation was obtained from other departments so that many of the in-patient referrals received complete

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[140] Kessel et al. note in another context that '[c]entres for the treatment of poisoning... exist primarily to resuscitate, not to retain patients for subsequent psychological treatment.' Kessel, McCulloch, and Simpson, "Psychiatric Service," p.987.

[141] Kreeger, "Initial Assessment," p.96.

[142] Ibid.: p.92.

[143] Ibid.: p.94.

[144] Ibid.: p.96.

[145] Ellis, Comish, and Hewer, "Attempted Suicide in Leicester," p.560.

[146] Bridges, Koller, and Wheeler, "Psychiatric Referrals," p.171.

psychiatric treatment in a medical or surgical bed.'[147] However, they complain that they have 'very few psychiatric beds' and that it is a 'somewhat unsatisfactory temporary use of general beds' for referrals to be treated thus.[148] They are quite diplomatic when they relate that '[t]here is always understandable pressure from physicians and surgeons for these ['attempted suicide'] patients to be transferred or discharged as soon as possible to allow further use of the bed,'[149] but therapeutic resource conflict looms large.

It is in this wider context that they argue 'we have found that 3 days observation at least is required for the majority of patients attempting suicide.'[150] This period of time is necessary so that 'the mood can be more accurately assessed, a social history may be obtained and the *visitors may have facilitated the resolution of crises*.'[151] What is crucial about this argument is that there are not only practical factors advanced in favour of continued occupancy of the bed (mood assessment and social history-taking). The visitors, cast as the social circle, are deployed as a reason for keeping a general hospital bed occupied by an 'attempted suicide' patient. No amount of extra resources or efficiency in psychological assessment can speed up this 'visiting' process that helps in the 'resolution of crises'. This is the precise opposite of Kreeger's thesis, but deployed in the same cause. For Bridges, Koller and Wheeler, the social generation and *therapeutic* repercussions of an 'attempted suicide' become a subtle but effective insulator against the quick discharge pressure from physicians and surgeons.

Kessel's potentially psychopathogenic 'social constellation' works differently again, to maintain a base for psychiatric *credibility* within the general hospital, but is no less embedded through the tactical battle between therapeutic approaches. He and McCulloch (imagining the plight of other hospitals) clearly show how the pathological 'domestic situation' calls for inpatient admission (which produces a need for further psychiatric beds):

> 'people who poison or injure themselves are brought to *hospitals* and the physician or surgeon calls for psychiatric help. After physical recovery, if admission is needed to remove patients from an explosive domestic situation this will have to be to a psychiatric bed. Asylum is not a word psychiatrists use much nowadays, nor are they keen to bestow it. Yet many of these patients need a temporary refuge.'[152]

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[147] Ibid.: p.178.
[148] Ibid.: p.180.
[149] Ibid.: p.179.
[150] Ibid.
[151] Ibid. Emphasis added.
[152] Kessel and McCulloch, "Repeated Acts," p.92. Original emphasis. Stengel curiously undercuts the case for conflict over beds, arguing that '[m]any ['attempted suicides'] will be given an appointment in the

Psychiatric credibility and the psychiatric claim to further scrutiny of these patients in a general hospital setting is *based on a vision of domesticity created by that very scrutiny*. Kessel and McCulloch's 'explosive domestic' situation, having been enabled by specific PSW practices, is now abstracted to general relevance in a claim on scarce resources. Instead of arguing for extended occupation of a 'general' bed, Kessel and McCulloch turn this resource conflict into a call for more psychiatric inpatient space in a general hospital. Thus practical, tactical, resource concerns have a crucial role to play in the systematic emphasis placed upon the 'social constellation' around an 'attempted suicide'. These 'social constellations' are substantially sustained by this politiking across the well-maintained split between general medical and psychiatric therapeutics. Thus 'attempted suicide' emerges at a critical part of the integrative project expressed by the Mental Health Act 1959 to bring mental and physical therapeutics to equivalence. The production of a potentially psychopathogenic 'domestic space' plays a key role in claim-staking in a general hospital environment.[153]

The new model of psychiatric integration eclipses the observation ward in favour of diverse DGH practices. However, the one example in this chapter that seems closer to the older model avoids these conflicts. The closer connection of Snaith and Jacobson's Brighton Emergency Unit to Haywards Heath Mental Hospital enables the work of the unit to be cast as saving resources that would otherwise be used by the mental hospital, rather than the possible usurping of 'general medical' beds:

> 'The Psychiatric Emergency Unit in our catchment area has served various useful purposes… had only half of the 220 patients disposed of in other ways by the Unit, been admitted to that psychiatric hospital and had the average length of stay of these patients been 2 weeks, then a further 8 to 9 beds would have been required at the psychiatric hospital'[154]

They do state that the 'value of the observation ward to the efficient running of the psychiatric hospital is of course far more than one of pure "saving" of beds.'[155] However this seems to be a much more positive account. This means that the new model of integration proposed by the *Hospital Plan* brings psychiatric expertise into DGHs in a much less established position, without recognised support when dealing with cases such as 'attempted suicide' that have a

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psychiatric outpatient clinic... hardly more than one out of five, require to be transferred to a psychiatric department for further treatment.' Stengel, "Attempted Suicide: Management," p.235.

[153] Compare with physician J.K. Slater's claim-staking over Ward 3 which emphasises somatic characteristics of 'poisoning' (chapter two).

[154] Snaith and Jacobson, "Observation Ward," pp.24-25. This argument echoes Norris, *Mental Illness*, p.94.

[155] Snaith and Jacobson, "Observation Ward," p.25.

secure foot in each therapeutic camp. This feeds into the conflicts over resources which then lead to the deployment and further entrenchment of the 'social constellation', the 'psychosocial appeal.' Thus 'attempted suicide as cry for help' might be more likely to become established in general hospitals as this new model of integration – and the attendant conflicts – take hold.

'Splitting and Inversion' and established patterns of behaviour

It is precisely the success of the establishment of this 'attempted suicide' that means the 'social constellation' can be used in such conflicts. The consistent establishment of practical arrangements transforming physical injuries into 'attempted suicide' and fabricating a 'social constellation' means that the latter ('social constellation') can be used to explain the former ('attempted suicide'). This is a gradual process occurring throughout the post-war rise of this epidemic phenomenon. In rather technical, esoteric terms, the success of these practices allows the social constellation to be 'split and inverted', and to become productive of 'attempted suicide'. The mechanics of this process are well-explained by Roger Krohn, who draws upon Bruno Latour and Steve Woolgar to claim that 'the constructing sentences are split from their imaginary objects, and then the now real objects are assumed to have caused the sentences.'[156] Krohn is talking about images and diagrams, but this is a useful concept to explain how referral, PSW interviews and psychiatric scrutiny, brought to bear on patients *first encountered in a hospital* can be used to create a pathogenic social space.

A patient arrives at A&E with a certain kind of injury (poisoning), possibly unconscious or semi-conscious, and practices of referral are required in order to question and assess the patient from a psychological point of view, after somatic treatment (possibly stomach washing). Somatic treatment does not require an extensive reconstruction of the precipitating or family circumstances. However, this is the *principal aim* of psychological scrutiny, to produce a social situation once a 'physical injury' has been referred for assessment. This situation then gets 'split' from the practices that produce it and 'inverted' so that it is positioned as *prior* to the episode, and can now *cause* it.[157] This is possible because 'social stresses' (present) or 'predisposing factors' (past) act as a conceptual bridge between circumstances and a behavioural pattern. Hence, statements that 'marital disharmony' or 'broken homes' cause 'self-poisoning' are possible, when viewed from a hospital ward. Once this process begins to recur predictably, the positioning is not so simple: the practices and the projections become mutually constitutive.

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[156] R Krohn, "Why Are Graphs So Central in Science?," *Biology and Philosophy* 6, no.2 (1991): p.197.
[157] As Krohn expresses it: '"split and inverted" in the suggestive phrase of Latour and Woolgar'. Ibid.

It is at this point of mutual constitution, when meanings and social spaces and pathogenic or therapeutic relatives are established, and then deployed to reinforce the scrutiny that produces them, that the object can be considered 'established'. This self-reinforcing process can spread and, to quote Hacking, 'new possibilities for action' can become 'a culturally sanctioned way of expressing distress.'[158] However, as has been argued here, this concept of 'distress' is linked to 'socially directed' or 'communicative' behaviour in such a comprehensive way that there is not much value in using one to explain the other in the case of 'attempted suicide'. Indeed, explaining a 'psychological epidemic' of *anything* during the twentieth century, using the language of 'distress', begs more questions than it answers given the way that 'distress' is constituted at the heart of – and conceptual guarantor for – the new project of psychiatric epidemiology.

Notions of 'incidence' – how regularly this phenomenon occurs – require further analysis in the establishment of this object. For a behavioural pattern to be considered 'culturally sanctioned' it must be widely, perhaps even self-evidently intelligible. That is, the meaning of 'attempted suicide' must be obvious and agreed upon. Once this happens, it becomes just another meaningful action that humans might perform in relevant situations. 'Attempted suicide' becomes a widely intelligible response to interpersonal difficulties. Thus a final shift outwards can be discerned, away from and beyond the 'technical' situation described throughout this thesis where objects are produced and stabilised, through exclusions and emphases, in certain fields of enquiry made possible by various techniques and practices. When this 'information is general' in Kessel's phrase, *people might actually start doing it more often*, feeding back further into the 'rise' of the behaviour to 'epidemic' proportions.

Conventional notions of 'incidence' and 'epidemics' need to be radically reconceptualised. The analysis of social phenomena such as an 'epidemic of self-poisoning' through body-counting and statistical compilation and computation are severely limited. Not only do these approaches run these two stages together, but collapses the first 'technical' stage *into* the more simplistic second stage where more people are able to start acting in newly-established, resonant ways.

'Parasuicide'

The conceptual endpoint of this thesis is the 'establishment' of this model of 'attempted suicide'. However, approached in the manner outlined above, this is almost impossible to pin down to a specific date. An approximation (more convenient than conceptually valid) is the proposal of the neologism 'parasuicide' in 1969. It is proposed mainly by Norman Kreitman and

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[158] Hacking, *Rewriting*, p.236.

psychologist Alistair Philip from the Edinburgh Psychiatric Epidemiology MRC Unit; Steven Greer from UCH and Christopher Bagley from the MRC's Social Psychiatry Research Unit at the IoP are also signatories to the letter to the *BJP*.

'Parasuicide' is advanced on the basis that the phenomenon is current, important and generally established. Proposing the new term, it is noted that:

> '[t]he only point on which *everyone seems to be agreed* is that the existing term "attempted suicide" is highly unsatisfactory, for the excellent reason that the great majority of patients so designated are not in fact attempting suicide.'[159]

The neologism is also part of a local effort to refocus the Edinburgh Unit's energies; having drifted rather aimlessly since Kessel's move to Manchester in 1965, Carstairs' move to be Vice-Chancellor of York University requires that the Unit be reconstituted around a new Director. The unit is reformed around Kreitman's organising theme of 'parasuicide' in 1971 and the neologism certainly gives the re-founding proposal a pithy coherence.[160] However, this local context should not obscure the more widespread agreement that a stable and distinctive pattern of behaviour exists. It is based upon the newly *self-evident* fact that the 'great majority' of 'attempted suicides' are not read as having an uncomplicated intent to end their lives but are in fact doing something else: something communicative and social. This seems as good a point as any to argue for the secure establishment of a psychological object.

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[159] Kreitman et al., "Parasuicide," p.146. Emphasis added.
[160] See: 'Reconstitution of Unit: memo to MRC on research in progress and copy of the refounding proposal from Dr Kreitman, 1970-1972' TNA: PRO: FD 12/412.

Conclusion

Towards the end of an article entitled 'Psychiatry in the 'Thirties' (1975), Eliot Slater observes that '[t]he young in those days did not have today's facilities for drug addiction, for self-inflicted wounds, for attempted suicide as a "cry for help".'[1] What seemingly starts as a comment on the increased level of drugs circulating in 1970s society, strikes a much more profound note by the end. In the 1930s, the 1970s patterns of 'attempted suicide as a cry for help' are simply not available. In the twenty-first century, whilst not invisible, 'self-poisoning as a cry for help' has been eclipsed by 'deliberate self-harm', based around 'self-cutting' for emotional (and even neurochemical) self-regulation.[2]

Between the 1930s and 1970s a number of objects under a variety of names (attempted suicide, pseudocide, self-poisoning, parasuicide) emerge through traffic between the therapeutic approaches of general and psychological medicine. Throughout the middle third of the twentieth century the relationship between psychological and general medicine is reconfigured, and the concepts used to interpret, treat and analyse patients presenting at hospital with a 'physical injury' are subject to much change. Actions configured around violence and a fear of imminent fatal repetition give way, slowly and unevenly, to actions interpreted as a result of childhood trauma, or attempts to communicate social and domestic stresses. This is not just a change in interpretive strategy, with some form of object constant beneath these different responses: the objects are fundamentally reconstituted in different contexts, by different practices.

The 'police watching' controversies articulate a 'would-be suicide' object due to a financial dispute between the police and voluntary hospitals. The potential for violence and repetition is emphasised as part of a strategy by hospitals to compel police to remain in attendance whilst the patient is treated. The potential for immediate repetition also implies that the 'attempt' is aimed at death. A dispute then emerges between workhouse infirmaries and voluntary hospitals which again emphasises violence, but this time in order to place 'attempted suicide' within the remit of workhouse infirmaries, as they are supposedly equipped to deal with 'mental patients'.

Legislative changes in 1929 and 1930 abolish the Poor Law and promote the informal (non-certified) treatment of mental disorder. As a result, psychological and general medicine come

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[1] E. Slater, "Psychiatry in the 'Thirties," *Contemporary review* 226, no.1309 (1975): p.75.
[2] C. Millard, "Reinventing Intention: 'Self-Harm' and the 'Cry for Help' in Post-War Britain," *Current Opinion in Psychiatry* (2012 [forthcoming]).

into a closer relationship around (mental) observation wards attached to general hospitals. In many cases these wards are the old workhouse infirmary mental blocks, with workhouse infirmaries turned into local authority hospitals on the abolition of the Poor Law. This closer relationship gives Consulting Psychiatrist Frederick Hopkins consistent access to various 'physically injured' patients brought to his Liverpool observation ward. This arrangement makes visible an 'attempted suicide' precipitated by a number of social and constitutional factors, including 'domestic stress'. He remains aware of, but equivocal about, an old notion that 'attempted suicide' is principally a manipulative communication.

In 1948 the NHS is inaugurated, with mental health included in the comprehensive service. This removes any disputes about payment for certain classes of patient, and effects a closer connection between general and psychological medicine. This connection, as seen at accident and emergency departments for case of 'attempted suicide', is not sufficient to produce a social constellation around a 'physical injury' conveyed to hospital. The presence of psychological medicine is still too marginal in casualty departments, where the overwhelming focus is acute somatic medicine. However, in the early 1950s, at an observation ward in Edinburgh, facilities for the treatment of poisoning, psychological scrutiny and psychiatric social work (PSW) expertise all converge. This results in psychological scrutiny of physically injured patients, but also the rooting of psychopathology (through the conceptual apparatus of John Bowlby) in childhood emotional deprivation in 'broken homes'. Psychiatrist Ivor Batchelor and PSW Margaret Napier operate in tandem to construct a vision of psychological maladjustment and low stress tolerance in the background of 'attempted suicide' patients. This is largely achieved through intensive questioning and assiduous follow-up by PSWs. A similar object is constructed around the same time in London observation wards by Erwin Stengel and co-workers. This 'attempted suicide' is again part of a crossover between mental and general medicine, but more focussed upon a present-centred (often unconscious) appeal, in response to social difficulties.

In 1959, the final legal impediments to psychological treatment at general hospitals are swept away, with a widespread effort to eliminate the differences between the treatment approaches as far as possible. Connected to this effort, and using Stengel's research, suicide and attempted suicide are decriminalised in England and Wales in 1961. These Acts prompt government guidance to hospitals recommending psychological assessment for all 'attempted suicide' cases seen at accident and emergency departments. This is actively followed up by the Ministry of Health, showing the difficulties of focusing intensive psychological scrutiny at casualty departments.

Whilst the government is passing legislation, the Medical Research Council sets up a Unit for psychiatric epidemiology that ends up in Edinburgh, at the same ward that produces the early 1950s studies. With the MRC's backing, Neil Kessel embarks upon a project to study the 'attempted suicide' that he renames 'self poisoning'. Making liberal use of PSWs, Kessel roots 'self-poisoning' firmly in the present, and as a conscious appeal, in an all-encompassing category of 'distress', centred upon a feminised vision of the home and 'marital disharmony'.

Finally, as the government starts to run down the asylum system and promote psychiatric units in general hospitals, large numbers of studies, with varying degrees of psychological scrutiny, are able to effect the transformation from 'physical injury' at casualty to 'socially-rooted appeal'. The growing self-evidence of the social constellation – a product of much intellectual and practical effort nonetheless – means that it is increasingly *presumed* around a casualty admission for poisoning. This presumption makes the behavioural category increasingly stable, public and *available* as an intelligible human response to interpersonal difficulties. This broader self-evidence fuels new terminological offerings, with 'parasuicide' the latest neologism.

In the present, 'deliberate self-harm' and 'postnatal depression' dominate crossover between general hospital presentation and subsequent psychiatric referral.[3] These clinical objects come to light due to processes of integration and referral similar to those described above. The organisation of therapeutic approaches and professional practices within healthcare systems remains critically important to understanding how and why health 'epidemics' emerge.

This account of the establishment and reinforcement of a behavioural pattern also has more intimate consequences. What humans can do, how we experience our emotions and perceive our possibilities are fundamentally contextual, situated issues. The turn to social, relational ways of understanding mental health and illness dominate the possibilities for personhood in the middle third of the twentieth century. The point of this thesis is to show how these possibilities for action or self-experience might come about. It details how broad administrative, therapeutic and legal structures and assumptions interact with local, credible, conceptual and practical labour. It demonstrates the crystallisation and reinforcement of a particular, resonant, intelligible behavioural pattern from infinite possible combinations. 'Attempted suicide as a cry for help' becomes an available human behaviour pattern. To understand how it is that we act as human, self-conscious beings, we must analyse how the possibilities for comprehensible actions are made.

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[3] Lloyd and Mayou, "Liaison Psychiatry," p.5.

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