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Early Twentieth-Century Self-Harm: Cut Throats, General and Mental Medicine

At some point before five P.M. on 25 June 1914, in the small coastal town of Lowestoft, Suffolk, 59-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:

> The [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 she 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, 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'.[4] There is acknowledgement of ambiguity around the issue of responsibility, but there is one certainty: '[T]he police are responsible for ensuring that ... at all events the offence shall not be repeated'.[5]

As this case is not read as a cry for help, and as it involves neither an overdose nor cutting of the arms, this might seem a strange place to start. The relevance of this case is that it shows how behaviour broadly conceived as self-destructive comes to the attention of hospitals (and more generally) in context-specific ways. Focusing upon how hospitals become concerned with self-harming behaviour before the ‘overdose as cry for help’ epidemic, between 1950 and 1980, sheds important light upon it. The idea of ‘self-harm’ as we presently understand it does not exist in 1914. The late-Victorian concern labelled ‘self-mutilation’ is significantly different, as it includes practices such as swallowing or inserting needles into oneself, self-castration, enucleation (eye removal) and eating rubbish, alongside the more familiar cutting, flesh-picking and self-biting. As Sarah Chaney clearly states: self-cutting ‘is not emphasised in nineteenth-century writings’.[6] We shall also see later how the early 1950s communicative attempted suicide is distinct. The Ashby case is an example of what is called a ‘would-be suicide’, a concern that involves hospitals and police, as well as workhouse staff and coroners. This chapter offers an explanation as to why a cut-throat would-be suicide is a concern in the early twentieth century and why, towards the late 1930s, it might be displaced by the beginnings of a different kind of self-harm, haltingly conceptualised in more social, interpersonal terms.

A Home Office file at the National Archives documents a series of disputes between hospitals and police forces in England and Wales over patients like Ashby, thought to have attempted suicide and brought to hospital by police (suicide and attempted suicide are illegal in England and Wales until 1961). On a practical level these records exist due to a debate about who is responsible for taking custody of 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 centres upon 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 the terms ‘renewal’ and ‘repetition’ are used interchangeably to describe this, renewal is preferred here to emphasise the difference between this concern and post-war usage. In the later period, ‘repeated attempted suicide’ indicates that a person resorts to an attempt at suicide at a number of different points, with each repetition considered distinct; subsequent efforts are not seen as trying to rectify the results of earlier suicidal episodes.[8] The second characteristic, ‘violence’, is more self-explanatory. However, in this context it is not always clear whether

the violence is imagined as predominantly self-directed or directed towards others (in the former case it is largely indistinguishable from a renewal of the attempt). Violence and renewal are central 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 this does 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 is not formally in the custody of the police).

In this way, characteristics of this would-be suicide are bound up with context-specific economic concerns. Some police officers see much police time lost on behalf of 'nervous medical superintendents' who push for police to watch most cases; on the other hand hospital staff express resentment at the police bringing in cases that constitute a drain on voluntary hospital funds.[9] 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. Care at voluntary hospitals is considered 'better than the poor law, if one could get it', but this is bound up with being deemed worthy of charitable relief, or having a letter of recommendation from a subscriber or governor.[10]

Part of this financial dispute mutates into a therapeutic dispute with financial consequences. This concerns violence again, but also a new category of 'restraint'. At issue in the therapeutic dispute is whether the most significant aspect of attempted suicide is the somatic, physical, injury or the presumed underlying mental disorder. Ideas of 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, claiming that their hospital (and others like it) are 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. Those in charge of the workhouse, the Poor Law Guardians, admit him. However, they do so without accepting the arguments of the voluntary hospital. Instead, they 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 and significance is also

related to a negotiation between the distinct therapeutic approaches of general and mental medicine. This division is constituted here between voluntary hospitals and workhouse infirmaries; mental hospitals refuse to take such patients until their physical injuries are stable. In addition, they also seem too geographically remote to be realistically considered in an emergency.

The respective positions of mental and general medicine shift in 1929–30, meaning that these debates over violence and restraint, over therapeutics and finance, recede somewhat. The archetype of the cut throat, and the violence and anxiety that surrounds it, is less relevant to the new context. Other methods and other readings begin to emerge, hand in hand with a sense of psychologically invested self-harm, where the goal of the behaviour is ambiguous – the beginnings of the concern with communicative self-harm. The Local Government Act 1929 abolishes the Poor Law, and the Mental Treatment Act 1930 broadens the scope for uncertified – so-called '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. These wards are associated 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 communicative attempted suicide, through the opportunity for psychiatric scrutiny of patients presenting at hospital due to a physical injury. The methods most commonly reported here are coal gas, liquid corrosive and medication poisoning. Poisoning thus seems to resonate with the psychological ambiguity that becomes well-established in the 1960s. Hopkins's object emerges through an uneasy negotiation 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'.[11] The practice of mental and general medicine changes, as do the differences and negotiations between them. However, because this object 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, in a liminal space between these two regimes.

Renewal, responsibility and economics

In the case of Louisa Ashby, as noted, the Home Office decides that it is the police's responsibility to ensure that 'the offence shall not be repeated'. This concern with repetition or renewal also surfaces in a dispute over one Frederick Newman in Wiltshire in 1915. In this case the Home Office decides that although 'no charge of attempting suicide was made against him there was some risk of his repeating the attempt'.[12] The police are reluctant to charge a person with the offence of attempting suicide, because this involves taking responsibility for that person. However, hospitals consider such individuals as patients who need to be watched. Thus 'would-be suicides' emerge here (and are recorded as such) according to the quality of renewal.

This is inseparable from economic concerns. In 1914 the clerk of Lowestoft Hospital's Management Committee initiates the exchange over Ashby with the Home Office, emphasising 'the heavy expense which the Institution has to bear in the care of these Patients'.[13] The Home Office appears sympathetic to 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. Reginald McKenna [Home Secretary] would be glad to know whether the question of making some contribution to the Hospital from Police funds has been considered'.[14]

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 due to economic necessity, the force has decided to stop performing duties that they believe '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'. However, they are 'prepared to do so in the comparatively few instances where the patient exhibits a desire to repeat the attempt, or is really violently disposed'.[15] In this way, 'would-be suicides' are characterised in terms of a specific debate around economics, to do with repetition and violence. 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'.[16] This economic concern brings out renewal and violence together, demonstrating that key qualities of this object of concern (its potential to be repeated and its violence) emerge directly as a function of a specific economic negotiation.

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. In the early twentieth century, workhouse infirmaries are places where mental and general medical therapeutics co-exist to a greater extent than in many other institutions. The involvement of this boundary between therapeutic regimes in the emergence and persistence of attempted suicide runs throughout this book. However, it is constituted and negotiated in different ways in different contexts. In this particular discussion, the issue of appropriate 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 these patients 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'.[17] This seems more to do 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: 'Medical 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'.[18] However, moralistic 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 workhouse infirmaries and voluntary hospitals are considered – from a legal standpoint in any case – equally valid.

In 1920 it emerges that the Liverpool police do not take would-be suicides to voluntary hospitals. They judge the workhouse infirmary especially suited for such cases due to the 'qualified persons' there. For this reason, extra expense on police watchers 'hardly seems justified'. 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: 'The 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'.[19] 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 of ordinary hospital staff (i.e., not trained to deal with mental illness). 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'.[20] The idea of a potentially violent would-be suicide is in a central position in an economic battle that is also fought around assessments of appropriate facilities.

It is unsurprising that would-be 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 that 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 separate therapeutic regimes

The intimate relationship between assessments of violence and the suitability of general or mental therapeutics 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 27 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. One result of the dispute is that the patient is ferried between institutions in search of treatment. At the inquest into his subsequent death it is observed that '[i]t is very hard to give a dying man a "joy ride" between hospital and hospital'.[21] 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 these mental blocks of Poor Law infirmaries such as Lake Hospital. Hugh Freeman notes that Poor Law Union infirmaries are built during the 1860s to care for the increasing number of 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.[22] 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'.[23] St Francis's observation ward in South London, the source of much of the clinical material in Stengel's *Attempted Suicide* (1958), is part of the Constance Road Workhouse from 1895 until 1930, when the institution is renamed St Francis' Hospital.

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'.[24] 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.[25]

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, 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'. A cut throat evinces a suicide attempt which, in turn implies violence. Thus, the facilities at the district infirmary claimed to be unsuitable, and they should not provide (or pay for) treatment.

The following exchange, reprinted in *The Reporter* newspaper, shows how seemingly exclusive mental and physical therapeutics become absolutely vital to the resolution of this case. Dr O'Connor, assistant medical superintendent at 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'. 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 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 Lake Hospital) clearly understands this as he replies that they do not have any male nurses either: 'We only have the mental ward attendants'. The coroner's reply explicitly positions attempted suicide as more mental than somatic before eliding this into a supposition of potential violence through the method of injury: 'Well, 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'. 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 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'.[26]

The negotiation of psyche and soma takes place 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 for violence emerges between therapeutic techniques.

The *Manchester Guardian*'s report emphasises the financial aspect over the therapeutic dispute.[27] However, rather than reduce the significance of the case to any one primary cause, it is useful to sketch out the arguments pursued in these 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 is to lay out a field of argument, structured by a specific mental/physical divide, where attempted suicide emerges.

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 most visible method until the 1980s in Britain – is passive, and that cut throats used in the overwhelming majority of disputed cases here is an active and violent method. However, this book seeks to understand why certain methods emerge in certain contexts, in the course of specific debates. 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 both 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.

If we accept that there is no 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. 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 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 renewal, it might be argued that this has nothing to do with the context and that it is merely logical that a person who attempts to commit suicide and fails would be likely to renew the attempt, to complete the suicide. However, it is precisely a disruption of this

logic that undergirds the post-war epidemic, arguing against ideas of attempted suicide as bungled or incompetent. The idea of repeated suicide attempts certainly emerges in the post-1945 discussions, but as noted above, this repetition is cast as a repeated response to social situations, an habitual coping mechanism, rather than as an immediate attempt to rectify the failure of the first attempt.

The violence largely disappears, and the repetition is fundamentally reconstituted. However, one aspect of these disputes flags up a subtle link between the attempted suicide of the 1920s and that of the late 1950s and 1960s – in addition to the idea that both emerge in the borderlands between mental and physical medicine. This concerns 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. 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'.[28] 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'.[29] In 1916 the Metropolitan Police commissioner states that the discretion over a charge for attempted suicide is 'based partly on the question whether the offender had any friends or relations willing to take charge of him'.[30] 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 supposedly nervous medical superintendents.

So whilst the notion of attempted suicide as cry for help has broad ancestry, it seems possible that the understanding of attempted suicide as primarily a communication with a social circle becomes more obvious 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 being a 'prototype' of a later version of attempted suicide. During 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 in relation to a person's mental health. It is also the case that concerns about social issues – such as child guidance, marriage guidance and mental hygiene – emerge between the wars (see also Chapter 2). These concerns, which are decisively adopted

by the state post-1945, feed into the self-evidence of the 'social setting' and its impacts. 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, and in a legally ambiguous situation, might also provide a basis (and an audience) for communicative self-harm.

Attempted suicide emerges at a point where confusion is 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 communicative self-harm in the Home Office and police files; instead there is a danger of repetition and a threat of violence (which does not consistently differentiate 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 for watching those recovering from an attempt) might encourage the apparent self-evidence of an attempt at suicide performed as a communication to a social circle, a cry for help.

These disputes form a 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 assume responsibility for these cases. 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.

From workhouse infirmary to mental observation ward (1929–30)

The disputes in the 1910s and 1920s bring would-be 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 a much more complex space than suggested by the polemic pursued in the Ashton inquest. They become more prominent during the 1930s as mental observation wards. To sum up mental observation wards in early-to-mid-twentieth century Britain is difficult. 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'.[31] They vary widely in their functions and available resources, according to place and over time. These disclaimers aside, an interwar observation ward might cautiously be characterised 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 temporary care of cases deemed acute, disruptive or difficult – often with the implication that mental abnormality is behind such behaviour. This workhouse heritage is widely acknowledged in the literature produced in the early 1960s around general-hospital psychiatric units. In 1963, two clinicians 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.[32] 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.[33]

The wards are transformed around 1929–30. First 'the Local Government Act [1929] placed the old Poor Law Hospitals under local authority control'.[34] In 1938 a report on London observation wards 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'.[35] The Act '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'.[36] 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.

The 1930 Mental Treatment Act (or the preceding Royal Commission, 1924–6) is often the starting point for twentieth-century histories of the integration of general and mental medicine in Britain. Walter Symington Maclay, a key figure in post-war mental health policy, is a keen advocate of integration, attempting to 'bring psychiatry into the

stream of the rest of medicine'.[37] When, in 1963, he lays out three crucial 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'.[38] Whilst he considers the Lunacy Act (1890) and Mental Deficiency Act (1913) important, the 1930 Act 'ushered in the era of mental disorder as an integral part of medicine'.[39] The Act's integrative impact is widely recognised. In *Social Science and Social Pathology* (1959), Barbara Wootton quotes the preceding Royal 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'.[40] In Maclay's reading, especially, the story of twentieth-century psychiatric progress in general seems identical with the processes of integration between general and psychiatric medicine.

The act enables local authorities to establish psychiatric outpatient clinics, and treat patients without formal certification, integration that is also helped by local health authorities appropriating observation wards and consolidating them into general hospitals. It is not often made clear enough that observation wards constitute a key intersection between general hospitals and mental medicine. This perception is central due to the enduring association between observation wards and attempted suicide.

Observation wards: diagnostics and the contested nature of treatment

In 1937, the *Journal of Mental Science* publishes an article describing St Francis's observation ward. Attempted suicide appears here as a distinct object: there are '33 cases of attempted or threatened suicide' admitted under Section 20 of the Lunacy Act and '12 suicidal attempts' admitted by police officers.[41] No further comment is given; the attempted suicides are not seen as a special target for investigation, but they are a distinct entity. In the 1938 report on the six London County Council (LCC) observation wards (by Aubrey Lewis and Flora Calder), patients 'with suicidal tendencies' are counted among the groups 'peculiar to observation wards'.[42] 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]'.[43] Lewis and Calder note that these wards are 'somewhat isolated from the whole system of the mental health services'.[44] Positioned between psychic and somatic therapeutics,

and significantly associated with attempted suicide, the observation ward's attributes in the field of security and restraint are key in associations with attempted suicide.

During the interwar period observation wards are intended to accommodate patients on a temporary basis, but this does not mean that they take voluntary patients. (The increasing levels of non-temporary elderly patients, stuck in observation wards because there are no suitable places for them to go, is a cause for considerable concern.) Patients are usually detained for an initial three days; before this period expires a magistrate is required to see the patient. Detention can then continue for a further 14 days.[45] After this combined period of 17 days, the patient is usually either sufficiently recovered to be discharged or needs to be transferred, whether voluntarily or involuntarily to a psychiatric hospital. This time is usually spent observing patients in order to diagnose them prior to disposition, but this process becomes augmented by a growing (though contested) treatment role.

During the 1930s '[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'.[46] 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. The Board of Control (the national body that until 1959 oversees and regulates mental treatment in England and Wales) is against this, arguing in 1935 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 for successful treatment'. The board further states: 'Every 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'.[47] 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 specialised mental hospitals.

This effort to keep mental treatment solely within mental hospitals is undermined by the wards' agreed role in diagnostic clearing. In 1940 the impossibility of separating psychological investigation from treatment is explicitly stated: 'Investigation *is* treatment – as those who deal exclusively with psychoneuroses constantly emphasize'.[48] Such investigation is central to the wards, in their role as a diagnostic gateway: there is

'a tendency to regard them [observation wards] as psychiatric casualty-clearing stations'.[49] The military language of 'clearing station' is significant, given the established links between the First and Second World Wars and the proliferation of psychiatric techniques.[50] 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: 'Prior to the present war, this unit was designated a "clearing hospital"; but the nomenclature was altered to "casualty clearing station" soon after the commencement of the present campaign [the First World War]'.[51] These clearing stations come to prominence during the 1914–18 war, but it is in the Second World War (1939–45) that frontline psychiatric treatment is carried out in them.

There is also a non-military parallel, seen as David Armstrong traces twentieth-century social medicine back to a tuberculosis dispensary described as 'a receiving house and a centre of diagnosis ... a clearing house and a centre for observation ... a treatment centre'.[52] The functions of diagnosis, treatment and observation all feature in debates around observation wards. Given Armstrong's compelling argument that the logic driving the practice of this dispensary is the same as that driving community-focussed, social medicine, the imminent emergence here of attempted suicide, similarly rooted in social environments and relationships, is illuminating.

Observation wards are clearly implicated in the negotiation between psychiatric and somatic therapeutics, and some are even treatment centres in the 1930s: '[I]n 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'.[53] 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's and Calder's findings in 1938 are more in tune with the sharp differentiation desired by the Board of Control, stating that 'these observation units function largely, if not solely, as clearing stations'. They note that '[i]n none of the wards did we find any attempt at prolonged treatment of the patients'. The operative word here is 'prolonged'; they visit St Francis and quote the published article detailing its practices at length in their report.[54] It should not be forgotten – at the London wards explicitly – that psychiatrists who worked at the prestigious and world-leading Maudsley (psychiatric) Hospital also visited observation wards, especially the regular visits to St Francis' by Edward Mapother

(superintendent of the Maudsley before the Second World War) and then Aubrey Lewis (as professor of psychiatry at the Maudsley-based Institute of Psychiatry).[55] These special circumstances at St Francis are acknowledged: 'Few observation wards in other counties have consultant psychiatrists, officers and staff experienced in mental diseases, and all prognostic aids'.[56] Lewis and Calder end the report with a clear response to the treatment debate: 'The 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'.[57] The potential link with 'the social' or 'community' emerges explicitly.

Finally, observation wards are significantly associated with practices of physical restraint, which has an impact upon the referral of patients considered dangerous (either to themselves or others), regardless of how often such techniques are used. The observation ward's association with such patients has a history: a *Lancet* editorial from the 1930s characterises observation wards as a place for 'acute and dangerous mental illness'.[58] In the late 1930s one of the functions of the St Francis Ward was 'to secure the safe custody of patients pending their admission' to a mental hospital.[59] This role persists after 1945. 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',[60] suggesting a significant controlling or restraining function. The potential for restraint and security at an observation ward makes it more likely for attempted suicide to become associated with such wards during this period, based upon the truism that attempted suicides are dangers to themselves.

To summarise, patients are compulsorily admitted to an observation ward for up to 17 days so that diagnosis can occur and the necessity for mental-hospital admission can be ascertained; formal treatment is discouraged, but is sometimes carried out, regardless. Thus, interwar observation wards can be characterised in terms of diagnosis, treatment and security. Their role in diagnostic clearing marks them out as a boundary space between therapeutic approaches, where mental treatment *slowly* becomes more acceptable. 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 continues to emerge in these places due to the coincidence of mental and somatic concerns, reinforced by the secure provisions around mental therapeutics.

This chapter ends with one of the earliest attempted suicide studies in England and Wales. Whilst Stengel's work at observation wards throughout the 1950s is acknowledged as central in the twentieth-century concern around attempted suicide (see Chapter 2) the first published study of attempted suicide to emerge after the 1929 reorganisations and abolition of the poor law in England and Wales appears in 1937, a study conducted by Frederick Hopkins at an observation ward in Liverpool. This clinical object is fundamentally linked to the diagnostics, mixed therapeutics and secure nature characteristic of these wards.

Frederick Hopkins and attempted suicide (1937, 1943)

Hopkins is a rather obscure figure with an interest in child guidance (co-authoring an article on parental loss with Muriel Barton Hall[61]); in 1968 a lecture series is established in his name.[62] His work is mentioned above, describing three of the most numerous classes of patient (including attempted suicide) that pass through his former workhouse observation ward (in two divisions of a general hospital) at Smithdown Road (Liverpool) during the Second World War. The link with child guidance is important, as it links Hopkins with a profession committed to social management, which is drawn into the welfare state after 1945. In his 1937 study, 'Attempted Suicide: An Investigation', he relates that these two divisions potentially receive 'all cases of attempted suicide occurring in Liverpool'.[63] The association of these special wards with attempted suicide is made explicit. It has already been noted that in 1920 Liverpool police judge the workhouse infirmary especially suited for attempted suicides.[64] This is clearly related to the secure nature; the majority of those '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'.[65]

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: 'Severe 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'.[66] Even severe somatic emergencies make it to mental observation. As noted above, attempted suicide is one of three common reasons for admission. It is significant that the other two reasons – G.P.I. (since the establishment of the physical Wasserman test) and epilepsy are among the most securely somaticised mental disorders

of the period. There is also a sense that G.P.I. patients and epileptics both have the potential to be disruptive and/or violent. These two illness categories perform a negotiation between psychic and somatic medicine that is very different to attempted suicide, thereby showing that there is nothing fixed or inevitable about such crossover.

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: 'In 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'.[67] Hopkins is open about the therapeutic effects that occur in observation wards – social adjustment with friends and family – without actively carrying out treatment.

Similarly, the intensity of the scrutiny Hopkins brings to bear on the attempted suicide patients is unclear. His study is undertaken to find out which factors are most important in provoking an attempted suicide. 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'. 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'. He reveals that in a 1930s observation ward, with limited opportunities for psychiatric scrutiny, 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'. 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'. 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.[68]

This does not stop Hopkins from speculating about these psychological mechanisms and their significance, speculation that yields something rather similar to communicative self-harm in these observation wards. However, it is notable how cautious he 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 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.[69]

The transformations that are already happening in observation wards (having a consulting psychiatrist such as Hopkins on the wards, for example) bring the potential to re-evaluate attempted suicide.

Hopkins 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' as well as the most common method overall.[70] 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.[71]

However, Hopkins remains aware of his research limitations when appraising the stereotyped view 'that suicidal attempts by women are commonly of the demonstrative, attention-seeking kind, without real intent to terminate life'. He is cautious and equivocal about this, arguing that although such a view may or may not be justified, 'this investigation has shown that women are little less determined than are men'. Hopkins judges his research resources and opportunities too meagre to firmly establish a phenomenon or to generalise it. This is not to say that resources available for scrutiny (time, money, research assistants, etc.) correspond precisely to various characteristics of different research objects. However, some relationship does obtain between research objects and the level of scrutiny that produces them. The text quoted above seems at first a significant counterweight to the gender dynamic that appears so strongly in the textbooks, a dynamic that feminises attempted suicide. In fact, Hopkins has a gendered reason of his own: 'Impulsiveness, lack of knowledge and preparation result in fewer fatal endings to their [women's] attempts'.[72] Hopkins's gendering is achieved on the basis of impulsiveness and ignorance rather than on gendered

intent (although he acknowledges that the 'intent' argument has been made).

He again mentions the effort that has gone into his series: not only why the patient decided to carry out the attempt but also any prior circumstances. One of his key findings here 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.[73]

He has no doubt that the large number of cases concerning women aged twenty-five or younger (twice the number of men in this age group) is 'is due to the hazards of love affairs and of early married life, misfortunes in these circumstances bearing more hardly on the female'.[74] Thus a domestic-romantic social setting is projected from an observation ward, in order to explain an attempted suicide. This socially focused explanation is clearly linked to psychological notions of stress.

This domestic social constellation is focused upon the events immediately preceding the attempt, part of what Hopkins 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'. However, these exist in a dynamic relationship with much longer-term 'conditioning causes', which 'include characteristics of personality showing definite deviation from the normal (or average), and physical states that were the primary cause of changes in the mental attitude'. These more long-term factors are considered inaccessible to this research project. However, Hopkins is clearly aware of their import – again through his work in child guidance.[75] This interplay between past and present factors, either in the social environment or the broader domains of aetiology, is investigated and reconfigured by various 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's socially embedded object is very different to the financial disputes of police watching, in which rejected patients are ferried between institutions across significant distances. The referral arrangements at Smithdown Road mean that Hopkins is able to aggregate psychiatric evaluations of patients whose physical injuries require urgent somatic treatment in the first instance. The secure nature of the ward also encourages referral of attempted suicides, who have 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's research resources are still rather meagre.

At the Ashton inquest the essence of attempted suicide as either psychological or somatic is debated, corresponding to therapeutic regimes so separate that they are a 'joy ride' apart. After the reorganisations of 1929–30 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 their potential connection is also enhanced by referral practices mentioned briefly by Hopkins. The emergence of a socially embedded attempted suicide centrally concerns this secure and liminal therapeutic space. It helps to reconstitute attempted suicide as a new object for scrutiny. This liminality within general hospitals remains the focus in the next chapter, in the context of a radical extension of activity by the state in the arena of social work (especially child and marriage guidance) and socialised medicine (the NHS).

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