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Self-Harm as a Result of Domestic Distress

Minister of Health Enoch Powell's *Hospital Plan for England and Wales* (1962) is a familiar landmark in twentieth-century psychiatry.[1] In 1961 Powell's 'water tower' speech to the National Association of Mental Health eloquently launches the ideas contained within the plan.[2] It is an evocative portrayal of asylums as grand, obsolete monuments to Victorian ideas of mental-health care. There is much historiographical focus upon how the plan 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. This model, based upon the establishment of psychiatric units in district general hospitals (DGHs), involves a more intimate connection between general hospitals and psychiatry than do observation wards. The DGH psychiatric units promoted by the plan undercut the progressive status and bridging function of the observation ward.

A variety of referral practices, shown in the studies analysed below, demonstrate again how a certain kind of (socially directed) self-harm 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 to how far these approaches can converge upon patients. The approaches of general medicine (as well as specialisms such 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.

This chapter shows how attempted suicide is developed beyond psychological scrutiny in A&E and mental observation wards. The first half focuses upon a Medical Research Council psychiatric research unit in Edinburgh, where this object is reframed as 'self-poisoning'. This narrowing of focus from all the potential methods of damaging oneself to just one passes curiously unremarked. The self-evidence of poisoning seems clear in the 1960s, even if it is not so now. A strong research base enables Neil Kessel, Norman Kreitman and others to unify these cases under the blanket term 'distress' and project their causes into domestic space. The combined facilities for psychiatric evaluation and resuscitation (as well as access to PSWs) available at Edinburgh's Ward 3 are not widespread. After 1965, a number of studies emerge from various places – largely focused upon psychiatric units in District General Hospitals (DGH). The second half of the chapter analyses how these different hospitals begin to focus upon communicative attempted suicide. Its growing stability, intellectual credibility and increasing public health profile mean that it becomes fully established as an epidemic phenomenon. In 1969 it is renamed 'parasuicide' by Kreitman and others.

This development of self-poisoning and attempted suicide continues to make sense as part of the broad turn to the social setting. The social setting's impact upon mental health and well-being is described through concepts of stress, distress and coping, as well as the practical ministrations of social work. These developments allow mental disorder to be further reconceptualised as an interpersonal, fundamentally social phenomenon. Again, the effects of a broad political commitment to state-sponsored social support is clear. On a practical level, psychiatric social workers remain key to communicative self-harm (especially at Edinburgh), using the practice of home visiting to root this object in a pathologised domestic environment. Once it is established in domestic social space, this space is then increasingly presumed to cause self-poisoning. This still relies upon interactions between therapeutic regimes, but brings increasingly gendered dynamics of domesticity and emotionality into play.

In January 1959 eminent psychiatrist Denis Hill gives a talk to the MRC assessing their psychiatric research policy. Having studied neurology before the war, Hill succeeds Aubrey Lewis in the chair at the Institute of Psychiatry in 1966. In this 1959 review, he suggests the establishment of two psychiatric research units, one in psychiatric genetics, under Eliot Slater, the other in psychiatric epidemiology under George Morrison Carstairs.[3] Carstairs's unit becomes a central site for the study of attempted suicide during the 1960s. Formally named the Unit for

Research on the Epidemiology of Psychiatric Illness, this research unit (especially the work of Assistant Director Neil Kessel) focuses a high level of psychological research resources upon attempted suicide, developing the potential provided by mixed therapeutics and establishing a number of stereotypical characteristics for those thought to communicate their distress through self-poisoning.

The start of the unit's life in the late 1950s is chaotic. It is initially sited in London at University College Hospital, but when Alexander Kennedy, professor of psychological medicine at Edinburgh dies, Carstairs is awarded the chair and takes the unit with him in April 1961. Carstairs becomes the honorary director, and his heavy clinical and teaching commitments mean that it falls to Neil Kessel to provide much of the unit's direction. Aubrey Lewis awards Kessel distinction in his diploma in psychological medicine, and Kessel works with Michael Shepherd in the General Practice Research Unit at the Institute of Psychiatry, where he delineates the concept of 'conspicuous psychiatric morbidity' – a psychological disorder known to a patient's GP.[4] He conducts studies on neuroses in general practice and alcoholism.[5] 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 dean of the medical school and then postgraduate dean.[6]

Before the unit's transfer to Edinburgh, Kessel is not especially interested in attempted suicide; 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). However, almost all of Kessel's work in Edinburgh concerns attempted suicide, and he proposes an important terminological shift: calling it self-poisoning. This interest coincides with Kessel's attachment to Ward 3 at the Royal Infirmary of Edinburgh. The physical/mental overlap enabled by the ward is most clearly shown in Kessel's previously quoted comments that the ward provides for patients who require 'overlapping general medical and psychiatric care'.[7] The addition of intense research scrutiny and national attention post-Suicide Act allows the object to flourish.

Institutional and national 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', a claim which runs through almost all of their work.[8] Kessel's studies similarly argue that 'we observed more than 90% of all [attempted suicide] patients arriving at any hospital in Edinburgh'.[9] 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'.[10] This coverage of Edinburgh is even said to obtain if poisoned patients are first admitted to another hospital, due to arrangements to transfer them to Ward 3. It is also stated 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'.[11] Thus, practical arrangements – an established and well-publicised emergency procedure – allow the clinicians on a single hospital ward to speak of a city-wide phenomenon. Their claims to a complete rather than an arguably representative sample, mark Ward 3 as an exceptionally influential site of knowledge for attempted suicide. Kessel is cautious about projecting his conclusions beyond his Edinburgh sample (without questioning the completeness of that sample for Edinburgh). Other clinicians working at the ward see no reason for Kessel's caution, and claim that the Edinburgh figures are representative for Britain, 'as there is no reason to suspect that Edinburgh people behave differently'.[12]

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.[13] 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.[14] One study presumably prompted by the legal shifts is the effort of A. Balfour Sclare and C.M. Hamilton in Glasgow – a study that is dwarfed by the institutional and research potentials at Ward 3. Based in the Department of Psychological Medicine at the Eastern District Hospital, Glasgow, most of the study's patients are referred from the Glasgow Royal Infirmary. Over half of the attempts are said to be motivated by either 'marital and romance difficulties' or 'family relationship problems'. In many cases the authors of the study characterise suicide attempts as 'a final act of exasperated abdication from what the patient regarded as an intolerable situation'. They do not

see attempted suicide as a self-conscious appeal, but rather as a frustration reaction, a 'response to complex and overwhelming situations'.[15] Despite an established department of psychological medicine, this study does not appear to have an institution like Ward 3 to bolster its claims or a large number of full-time research psychiatrists and PSWs based at the hospital. Despite the Scotland-wide standing rule and the historic lack of legal constraint, this is just one more incidence 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. Further, Kessel's self-poisoning is rooted in an amorphous category of distress. This emotional state is thought common to all self-poisoning episodes, through which point of view 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. However, much remains the same under this new term.

Much of the intense scrutiny focuses upon the familiar issues of lethality and intent. These function as part of a debate between therapeutic regimes. Kessel and two social-work colleagues make it very clear in 1963 that physical danger to life and psychiatric pathology are to be assessed separately:

> [N]o 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, 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.[16]

There is a complex relationship between danger to life and a psychological disorder. Although they concede that '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'.[17] A year later Kessel and various collaborators talk of the dangerous fallacy of 'using this yardstick of physical damage to judge whether the patient needs psychological treatment'.[18] The clinical object exists between therapeutic regimes, but (somatic) lethality is downplayed. The communicative overdose remains a tactical intervention between therapeutic regimes where the significance of the act is determined not by its physical consequences but its psychosocial context.

The first major difference is the explicit archetypal method. In 1965 Kessel entitles his Milroy (public health) Lectures at the Royal College of Physicians 'Self-poisoning'. These two articles are key in further publicising the terminological debate around attempted suicide. Rather than accept Stengel's and Cook's increasingly established modification of the term, Kessel finds attempted suicide, 'both clinically inappropriate and misleading',[19] advancing self-poisoning because it allegedly' describes the phenomenon without interpreting it along a single pathway'.[20] However, Kessel is opening up and closing down various possibilities. His terminological offering is intended to sidestep issues of intention ('interpreting' here indicates assessments of intent), but collapses all possible behaviours into one archetype.

These lectures describe a rather unorthodox practice in the promotion of self-poisoning stereotypes. Kessel sends an actor into six chemist shops in Edinburgh, instructed to simulate being in floods of tears, and to request two hundred aspirin. Kessel reports that she was served in every shop and only once was concern expressed: 'Two hundred? Are you all right? You ought to go and have a cup of tea'. This state of affairs is described in strong terms as irresponsible.[21] This expresses the twin facts that a 'sobbing girl' is typical of self-poisoners and that purchasing a large quantity of aspirin in this state is obviously a suicide risk – which also narrows the method of attempted suicide.

Kessel concedes that definitions of self-poisoning are difficult and fraught with complexity, but he uses phrases like 'mimicking suicide', 'simulation of death', and 'drama was enacted for their own circle'.[22] Such phrases expose a simplification of intent: this is not Batchelor's and Napier's childhood emotional trauma surfacing, nor Stengel's 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'.[23]

Alongside this stabilisation of intent, Kessel's self-poisoning is based upon the stereotypical method, the assertion that distress is the one common feature in all self-poisoners, and an effort to present this as a predominantly female behaviour pattern. All these have resonances and connections with wider trends during this period, in a different register to their resonance with the commitment to social welfare. Poisoning with drugs is linked to anxieties about prescribing and pharmaceuticals (although illicit substances do feature in a small way). Distress is a broad conceptual foundation for the turn to the social psychological medicine in this period. The gendered character of self-poisoning is linked to a feminised vision of domesticity through psychiatric social work. These three parts of Kessel's self-poisoning are explored in turn.

Poisoning, overdosing and drugs: local and national concerns

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.[24] Awareness of the phenomenon of self-poisoning with drugs increases during the 1940s and 1950s. According to one Edinburgh toxicologist: 'The first resuscitation centre dedicated to poisoned patients' opened in Copenhagen in 1949. In England, the North-East Metropolitan Regional Barbiturate Unit was set up in Romford in the 1950s.[25] Comments made in the late 1950s by the head of the Romford unit indicate that certain forms of poisoning have affinity (in the eyes of some clinicians) with suicidal gestures: 'barbiturate poisoning is notorious in that it is not a particularly lethal variety of poisoning[;] [it] is important because of its frequency and not because it is highly lethal'.[26] He 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'.[27] Thus, ambiguity of method is transposed onto ambiguity of intent, giving this method increased visibility. However, there is nothing inherently ambiguous about this method; such a claim falls into technological determinism. The explicit, conscious nature of the appeal in Kessel's self-poisoning overrides any ambiguity

in the method in the above 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'.[28]

As we saw in Chapter 2, it is likely that the secure status of Ward 3 brings attempted suicides to prominence there, transferred for their own protection rather than because of any illegality (as attempted suicide is not an offence in Scotland). The Ward's poisoning associations shift from delirium tremens and alcoholism in the early twentieth-century through to attempted suicides, which is collapsed into poisoning and then broadened out to encompass accidental poisonings.

In 1962, a subcommittee of the Standing Medical Advisory Committee – under the chairmanship of Guy's Hospital Surgeon Hedley Atkins – issues a report titled: 'Emergency Treatment in Hospital of Cases of Acute Poisoning'.[29] According to a 1959 memorandum, this committee 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.[30]

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 in 1962 is designated a regional poisoning treatment centre (RPTC) in accordance with Atkins Committee recommendations. The Hill Report (1968), issued by a committee chaired by Denis Hill, reiterates the earlier recommendation that regional poisoning treatment centres should be established for the specialist treatment of acute poisoning.[31] 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'.[32]

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 during this period it becomes that way. The decline of carbon monoxide

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 – a trend studied in both Edinburgh and Birmingham.[33] These concerns show the narrowing that takes place when switching terminology from self-poisoning to overdosing – there is no normal dose of carbon monoxide, thus overdosing makes little sense as a description of this method.

The wider significance of the overdosing archetype is explicable partially in terms of anxieties around prescription medication. It is in this context that Stengel blames the increased availability and consumption of sedatives under the NHS for the preponderance of drug-based attempts.[34] Kessel agrees, claiming 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'.[35] The importance of drugs as the archetypal method of communicative attempted suicide continues to rise throughout the 1960s. 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'.[36]

Concerns around overprescribing are exemplified by Karen Dunnell's and Ann Cartwright's book, *Medicine Takers, Prescribers and Hoarders* (1972),[37] which is also part of the important and complicated issue of the supposedly meteoric rise of psychoactive medications in mental health care and the technologies of the randomised controlled trial (RCT).[38] 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 this 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.[39] 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.[40] There are well-publicised debates around cannabis, and when the Wootton Report 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.[41] In the midst this, Kessel's

narrowing of a behavioural stereotype around attempted suicide passes almost unnoticed.

Distress and the social constellation

The second of Kessel's key modifications concerns distress, a concept shown in the introduction as having inescapably social overtones. He explicitly adapts Batchelor's 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 through changing PSW practice. Furthermore, distress allows pathology to be projected onto individuals in the social setting rather than the patient admitted having self-poisoned – typically a pathologically jealous husband driving his otherwise normal wife to a suicide attempt. 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 to describe this phenomenon, but he is the first to unify it in this way.[42] He asks: 'Is there a unifying basis to self-poisoning acts? Is there some feature that informs them all?', then answering, 'Distress drives people to self-poisoning acts: distress and despair, unhappiness and desperation'.[43] Edinburgh PSW J. Wallace McCulloch and psychologist Alistair Philip declare in *Suicidal Behaviour* (1972) that '[w]e firmly endorse Kessel's statement that "*distress drives people to self-poisoning acts*."'[44] It is explicitly emphasised at the core of the behaviour.

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'.[45] 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'.[46] Asher does not see the increase in psychosomatic illness as part of a growing overlap between separate therapeutic regimes; rather, he attributes it to fashions in disease, just as Kessel talks of the 'fashion for survival' after self-poisoning.

There is a distinctively evolutionary angle to much work on stress. As we have seen, Walter Cannon and Hans Selye draw their insights from

animal experiments, and stress is theorised as an adaptive response applicable more broadly to animals and rooted deep in the evolutionary past (otherwise animal results have no significance for humans).[47] What is interesting about the ideas of distress mobilised by clinicians concerned with attempted suicide is the lack of explicitly evolutionary explanations, the use of animal experiments and ethology. Clearly, the concepts of distress and stress gain traction because of these influential explanatory systems. It seems futile to deny that the stress described here might rely at one level on unspoken evolutionary assumptions. On one hand John Bowlby's theories – used to underpin attempted suicide studies in the 1950s – come to have significant ethological underpinnings, but Erwin Stengel's work moves from a position of ambivalence (in the 1950s) to outright scepticism (in the 1960s) about the deep evolutionary underpinnings of attempted suicide.[48]

On the whole, distress functions as a broad, under-theorised blanket explanation, uniting concerns about '[s]ubjectivity, meaning, idiosyncrasy, feelings, a social nexus'.[49] Whilst Rhodri Hayward has shown that George Brown's and Tirril 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 withdrawal',[50] this emphasis is not overt analyses of attempted suicide in the late 1950s and early 1960s. 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 this term comes to stand in for the social environment: '[S]tress is external to individuals and emanates from the social conditions which govern their everyday lives'.[51] 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 in order to make sense in the post-war period. This distress, bound up in conceptions of the social environment may be self-evident in certain contexts, but Kessel's is also rooted in PSW practices – part of the state's commitment to psychosocial management.

Social settings and social workers – PSWs at Edinburgh and beyond

During the early 1960s, PSWs occupy a prominent place in Kessel's studies. He works most closely with PSWs Elizabeth Lee, then J. Wallace McCulloch, continuing the collaborative focus of Batchelor and Napier and Stengel and Cook. According to MRC records, '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'.[52] 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.[53] The broad shift towards community care brings social work to renewed prominence. In a 1968 textbook of psychiatry for social workers 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'.[54] As mental health care becomes increasingly organised around outpatient departments, 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.

Despite the health visitor–PSW training scheme, Kessel complains in 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'. However, a footnote acknowledges: 'This 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'.[55] Difficulties elsewhere are hinted at by John Wing in 1963, when he describes some of the arrangements for a psychiatric research project in London: '[T]here will be three social workers involved. It is not usually possible to find highly qualified, trained people for this work'.[56] We have seen in Chapter 2 how PSWs at Edinburgh impact upon the knowledge produced about attempted suicide. They broaden the spaces of investigation, from the various hospital spaces (the accident and emergency department, Ward 3, etc.) through home visits and follow-up, enhancing the credibility of any projections into those spaces. These visions of domesticity help to stabilise this phenomenon.

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'. He also notes that arrangements are made to interview a spouse or other relative (called a key informant), and this information is fed into a conference where 'social and clinical details

are put together'.[57] These are the practices upon which an interpersonal, social constellation is built.

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'. [58] Such histories are

> 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.[59]

This social constellation is not static. Changes are apparent during the 1960s as social workers are advised: 'Unless 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 minute details of family income and expenditure'. 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'. 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'.

Given McCulloch's interest in the subject, it is unsurprising that this co-authored textbook, *Psychiatry for Social Workers*, should accord a special place for social worker interviews around attempted suicide. It is noted 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'. Munro and McCulloch set out a scheme for the recording of data for the specific occurrence of attempted suicide, which includes the patient's indications of their

intent to others, the circumstances in which the attempt occurred, the measures taken to either ensure or avoid discovery and the reactions of relatives.[60] This is a revealing didactic practice for the consistent fabrication of a social environment around a presumed attempted suicide (rather than investigations of the patient's constitution or brain chemistry, for example). Kessel also sees the dramatic nature of self-poisoning 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 ... so as to extract the last ounce of drama from a situation in which he holds the centre of the stage'.[61] The language of deceit solidifies the self-conscious character of intent and shows its reliance upon social work practices.

The present, marriage guidance and managing the boundary of pathology

Kessel's self-poisoning is rooted in the present. Joan Busfield argues that the relationship between stress and mental disorder 'focuses not on events in early childhood but on an individual's more immediate situation'.[62] Whilst stress is not inherently present-centred, Kessel's modification of 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.[63]

As we have seen, Batchelor's and Napier's work pivots upon an acute frustration reaction linked to childhood emotional trauma. This thread re-emerges in 1960s attempted-suicide studies from University College Hospital (see below). Kessel and McCulloch instead emphasise present distress over past emotional deprivation, and the present social environment against the childhood emotional environment. Kessel is also ambivalent about Batchelor's and Napier's reliance upon the concept of faulty adaptation: 'Whether the broken parental home is the root from which stems the disorganized life pattern ... must remain a matter for

speculation'.[64] Kessel instead relies upon notions of impulsivity rather than frustration: 'Two-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'.[65] This is a clear shift.

This move towards the present shows psychiatric social work's expansion beyond child guidance into marriage guidance, a movement founded in the 1920s with significant connections with PSWs.[66] 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. PSWs began to be trained in the 'psychology of family relations' from the late 1950.[67] These concerns also resonate within psychiatric research, for example Norman Kreitman's studies at the Graylingwell Hospital in Chichester in the early-mid 1960s into mental disorders and marriage. These studies draw upon the eugenic concerns of Lionel Penrose's study of 'Mental Illness in Husband and Wife' (1944) and Eliot Slater's and Moya Woodside's *Patterns of Marriage* (1951).[68]

This increasingly marital focus feeds into Kessel's present-centred distress. It is seen as 'the chief aetiological factor in many cases' and, in general, 'the attempt follows swiftly upon an acute domestic quarrel in a chronically disturbed matrimonial situation'. Batchelor's broken home is placed on an equal footing with the concept of a 'breaking home', which is present-focussed; the aetiology of the attempted suicide migrates from the past to the present.[69] Present marital disharmony is only a short step away from broader romantic, communicative interpersonal concerns. Kessel argues:

> Admission 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.[70]

The highly gendered nature of this communication is discussed below. For self-poisoning to be a powerful weapon it must be rooted in a present social context.

On a practical level, in 1964 Noel Timms sees slight but significant temporal changes in the social history: '[P]sychiatric 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'.[71] More theoretically, PSW Eugene Heimler argues in 1967: 'In community care the present plays an extremely important part ... the theory of psychiatric community care is this: the past influences the present, but the present also influences the past'.[72] Munro's 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'.[73] It is clear that longer-term factors can co-exist with this focus on the present, but the present-centred concerns of the mid-1960s throw the work of Batchelor and Napier into sharp relief.

This present-focused distress also forms part of a complicated relationship between abnormal action and psychiatric pathology. Kessel states: 'It 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'.[74] The focus upon marital relationships also has a significant role in managing the ambiguously pathological nature of 'distress'. Regarding self-poisoners, Kessel continues: 'Of particular importance is the fact that 26% of the men and 20% of the women had no psychiatric illness.[75] The pathology does not disappear: marriage and the social constellation allow pathology to be projected onto somebody who has not even been poisoned. McCulloch and Philip put this most clearly in 1972:

> [T]he 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.[76]

This idea of illness emerges right at the point where marriage guidance and psychiatry intersect. The figure of the jealous husband is given an entire chapter in J.H. Wallis's text, *Marriage Guidance: A New Introduction* (1968). Wallis ends his description with: 'The important question [is] whether this client may need psychiatric treatment', and he refers to that same problem: 'There 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'.[77] The social setting, psychiatric treatment and the boundary between mental health and illness

link psychiatrists, PSWs and marriage guidance counsellors around this object of self-poisoning.[78] The marital relationship is subject to intense psychiatric scrutiny through interviews, follow-up and case conferences.

Distress, domesticity and gendered self-poisoning

These practices are saturated with stereotypes of femininity. Nevertheless, this is a highly uneven gendering process, left unexplained or unmentioned; as Raymond Jack rightly points out the issue has 'been virtually ignored in the literature'.[79] There is certainly nowhere near as much crude gender stereotyping as that which pervades the late 1960s North American–based stereotypes of delicate self-cutting, which begin to seep into British practice by the middle of the 1970s (see Chapter 5). All three of Kessel's modifications (self-consciousness, poisoning and stress) have potentially gendered freight.

The additional self-consciousness feeds into stereotypes of feminine manipulation, exemplified by Kessel's above-quoted comment about bringing back errant boyfriends. Self-poisoning is also seen as a passive (read: feminine) method, which interacts with a gendered imbalance in the prescription of barbiturates. Ali Haggett states: 'Since 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 was to ensure that women "adapted" to their domestic role'.[80] Finally, distress has resonances with supposed feminine emotionality, but is also explicitly 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.[81]

This recalls Slater's and Woodside's home interviews of soldiers' wives in the late 1940s, where Woodside reports witnessing 'struggles and ambitions eventually adapting themselves to the limitations of a restrictive environment'.[82] Indeed, marriage, domesticity and psychopathology are historically well-connected.[83] This general emotional isolation and supposedly normal social setting are opened up for Kessel through PSW 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.[84]

Domestic stress is still gendered, not through Bowlbian maternal deprivation but through a feminine lack of resilience, or a masculine lack of support. These gendered gaps affect Kessel's way of framing and answering questions: 'Confirmation was thus provided of the clinical impression derived from dealing with the patients, especially the women in the ward, that marital conflict is the chief aetiological factor in many cases'.[85] The practice of holding a clinical conference with PSWs at Ward 3 has been made a rule by February 1963.[86] This co-operation 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. Thus, he is able to speak about domestic space through what is observed in a hospital ward. Once this clinical impression is confirmed, it can predominate, even to the point of overriding PSW input that helps to enable it: 'The 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'.[87] Visions of the home are created in these analyses, as part of the wider project that inscribes mental health and mental disorder onto the social, interpersonal fabric of everyday life.

The unequally gendered archetype is tackled explicitly by Kessel, who disagrees that self-poisoning is 'the female counterpart of delinquency in young men … [which] would suggest that women turn their aggression against themselves, while men act against society'.[88] He argues, instead, that self-poisoning is better understood through emotional isolation and failure to adapt to domesticity. 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 deviance), to a position made possible by the PSW-founded analysis of domesticity. This is a crucial component of his rendering of female-dominated self-poisoning. But it is not enough merely to state (and lament) the traditional association or, more precisely, mutual constitution of domesticity with femininity. Sexism is active practice, not merely a re-articulation of established associations.

Psychiatry, the social setting and women are closely connected during the 1960s. The influential *Psychiatric Illness in General Practice* (1966) goes so far as to say, '[I]t 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'.[89] A gender imbalance in communicative overdoses does not seem exceptional in the wider context of reading mental illness into interpersonal relationships. The idea that those gendered female are physically, emotionally, psychologically or evolutionarily more suited to domestic, home or family spaces, is a durable plank in circular sexist arguments that feminise domesticity *a priori*. This 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.[90]

During Kessel's time at Edinburgh, such critiques are far from the mainstream and, even afterwards, they struggle to make much headway in psychiatry. However, this 'maternal complex' is another part of the social commitment that is rolled back in the 1980s. Additionally, the move from past to present – from broken homes to pathological marriages – enables a specifically feminine aspect to self-poisoning to emerge. Broken homes affect both genders more or less equally, but this is not the case for present domestic problems. This reassertion of gender

difference 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',[91] an assessment echoed by Noel Timms in the post-war period.[92] Of course, the presence of those gendered 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 supposedly female profession. The child-guidance roots of PSWs carry significant gendered freight, 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':

> 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*'.[93]

This earnest and patronising picture is assessed with Timms' sardonic comment: 'The fairly high status accorded to the psychiatric social worker is somewhat diminished by the ambivalent comment in (my) italics'.[94] 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.

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, which falls away as internal emotional regulation and neo-liberalism rise in the

1980s, laying the ground for biologised understandings of self-harm as self-cutting. The practical arrangements carried out in hospitals in the mid-to-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.

Observation ward to DGH unit: practical integration and new crossover

After the Mental Health Act, the equation of mental with physical illness enables mental health care on the same deregulated basis as physical care. In practical terms, the integration of psychiatric with general medicine is attempted by casualty referrals, as we have seen, and the provision of psychiatric treatment units in DGHs. These units owe much to observation wards – in many cases, the wards become treatment units. Martin Gorsky argues that these units emerged in the 1950s and John Pickstone sees a tendency towards this kind of provision in the 1960s.[95] Walter 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'.[96] C.P. Seager claims in 1968: 'There 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'.[97] Now their treatment there is self-consciously attempted.

These units are a key plank in the government policy of scaling back mental hospital provision. The *Hospital Plan* states: 'It 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'.[98] One clinician observes in 1963 that '[w]hatever views may be held regarding the role of general hospital psychiatric units, they are increasing in number and influence, and their further development is accepted Ministry of Health policy'.[99] A team of clinicians at King's College Hospital (KCH) note in 1966: 'The 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'.[100]

Psychiatric literature during the late 1950s and early 1960s is full of comment upon these local and specific developments.[101] Maclay argues

in 1963 that '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'.[102] The desirability of these units goes beyond spatial advantages, and is far more about the administrative isolation to which mental medicine is still subject.

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'.[103] This also happens in London in the former observations wards at St Pancras and St Clements.[104] D.K. Henderson argues in 1964 that observation wards 'paved the way for the more highly specialised psychiatric clinics'.[105] From Brighton, R.P. Snaith and S. Jacobson concur in 1965: 'As 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'.[106] The move from observation wards to DGH psychiatric units focuses attention upon the unhelpful stigma of segregated mental treatment. However, this undercuts the standing of the remaining 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. Due to observation ward's secure and segregated nature and its enduring association with the Poor Law, it is undercut as a preferred method of crossover between psychiatric and general medicine.[107]

Manchester clinicians comment on the stigma of general hospital mental wards as early as 1949.[108] 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 that the transfer of all attempted suicides to observation wards is largely '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'.[109] 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 it provokes new conflict between therapeutic regimes.

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, as in a 1969 discussion of psychiatrist–physician liaison: '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' which include 'personality disorders of moderate severity, resulting from disturbances in the patient's parental family relationship'.[110] The significance of the social setting again emerges under these new arrangements.

Separated therapeutics, beds and referral

These units are not without conflict. Despite – or perhaps because of – closer spatial integration, the therapeutic conflicts that undercut cooperation become sharper. Psychiatry and general medicine remain separate in this period, involving dissimilar, sometimes incommensurable, therapeutic approaches. The lack of administrative differences between them exacerbates friction between therapeutic approaches. This is not a problem exclusive to the post-1959 period. Back in 1953, R.W. Crocket at the Department of Psychiatry in Leeds wonders 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'.[111] 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. A *Lancet* lead article puts it bluntly in 1962: 'The 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'.[112] Walter Maclay cautions in a similar vein 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.[113]

Despite this enduring difference, psychiatric access to general wards increases – for psychiatric consultants for example.[114] However, whilst psychiatric units might be close by and even wards might be mixed, the basic unit of resources in a hospital, the bed, 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: geriatric, paediatric, psychiatric or surgical. Thus to produce a psychosocial context around a physical injury arriving

at casualty – possibly also going for surgery or specialised resuscitation – requires referral to negotiate between these mutually exclusive spaces. Separation endures, as the walls of the asylum give way to the resource politics of mutually exclusive beds, an exclusivity founded upon ideas of 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.

Studies from Brighton, Leicester, Sheffield and Bristol, 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'. The Sheffield and KCH studies will be considered in detail below.[115]

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. This study is based upon records rather than clinical encounters, but referral practices between therapeutic regimes are still vital.

The general hospital group comes from three Sheffield General Hospitals. 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', it is admitted that '[a]ttempted suicide is not a diagnosis and therefore does not appear in the diagnostic index of hospital records'. 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'. These somatic categories are transformed by closer study from Stengel and Parkin. The somatic therapeutics of casualty are thus further negotiated by referral to an on-call psychiatric consultant.[116]

Patients who are admitted end up at the psychiatric departments of these hospitals, 'transferred ... after the state of medical or surgical emergency had subsided'. 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, negotiating the predominance and separateness of somatic therapeutics. They also 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'.[117] 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'[118] 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'.[119] This GP input is carefully managed. The second question, 'How many patients did you *suspect* of having made a suicidal attempt?' requires clarification 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'. 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'.[120]

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 attempted suicide 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'.[121] So whilst psychiatric expertise is not strictly essential to the production and maintenance of attempted suicide, significant intellectual labour to bring about an approximation is necessary.[122]

So whilst it may seem that general practice, or primary care, has been neglected in the wider story about the epidemic overdosing, it is simply that the organisation of health care in Britain makes it difficult and unlikely for attempted suicide to come under extended scrutiny in this area. C.A.H. Watts admits as much in 1966 when he comments that whilst '[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'.[123]

King's College Hospital Accident Service

There are six published reports from King's College Hospital (KCH) between 1966–9 either based around or with significant mention of attempted suicide. KCH has extensive geographical and practical links to the Maudsley.[124] P.K. Bridges and K.M. Koller (psychiatric registrars) and T.K. Wheeler (senior house officer) publish an account titled 'Psychiatric Referrals in a General Hospital'. They comment that a 'large part of the work in this department is concerned with patients who have attempted suicide', mentioning a 'regional accident service that has been developing in recent years[, and] which may partly account for the rising intake' of such cases. It is also argued 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'. There is also a rather opaque reference to 'increasing medical awareness of the potential significance of the suicidal attempt', which means that 'virtually all cases are referred to a psychiatrist'.[125] Bridges and Koller use the accident service in 'Attempted Suicide: A Comparative Study' in conjunction with a control group. The accident service is not specifically intended to bring attempted suicide into view but, due to this arrangement, there is a new potential field for clinical and research objects constituted through referral after somatic assessment: 'Virtually all cases of attempted suicide admitted to the hospital are referred for a psychiatric opinion'.[126] Bridges's 1967 remarks (from University College Hospital in North London) show the difficulty of establishing referral in accident departments, arguing 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'.[127]

Interested in this phenomenon in his early career, H. Steven Greer signs a 1969 letter to the *British Journal of Psychiatry* that first proposes the term parasuicide (alongside Norman Kreitman and psychologist Alistair Philip from the Edinburgh MRC Unit, and Christopher Bagley from the MRC's Social Psychiatry Research Unit at the IoP.).[128] 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 again mention the accident service, coupled with referral as key: 'Any patient who has made a suicidal attempt, however slight the medical danger, is admitted and referred for psychiatric opinion'.[129] This explicit mention of 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 'gestural' injuries potentially might only become visible to psychiatrists at general hospitals because they are sought.

John Bowlby's ideas of childhood psychopathology re-emerge as Greer and colleagues explicitly question these attempted suicides about childhood parental loss ('broken parental homes') and any 'recent disruption of close interpersonal relations'. 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'. 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'.[130] This predisposition (based on faulty childhood development) is a key conceptual plank enabling past or present social environments to cause attempted suicide. In another study undertaken by Greer and Gunn only, patients from 'intact homes' and those who had suffered 'parental loss' are compared.[131] Thus, people are 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.

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'. 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'. 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'.[132]

Finally from KCH, J.P. Watson (based at St Francis Hospital) also uses the Accident Service to construct a series in which 47–53% of patients present with a 'suicidal problem'. A case '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'. Thus psychiatry is defined, in practice, largely by the absence of other specialist attention. However, in psychiatry, one exception is made. The above definition comes with the significant qualification: 'unless he had deliberately poisoned or injured himself'. 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 emerges through practices that negotiate the separated therapeutics of the district general hospital, in casualty departments.

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's and Stengel's study, are designed to elicit an attempted suicide object, whilst still relying upon much wider systems of referral. Others, such as the KCH Accident Service, bring an attempted suicide to attention that is no less the product of human administrative intervention. Referral stands at the centre of these processes, right at the core of attempted suicide, 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 are useful when analysing how psychological, behavioural, clinical objects become established and self-reinforcing.

Social spaces embedded and established through the politics of therapeutic conflict

The final part of this chapter looks at how therapeutic conflict (rather than simply separated therapeutics) provides extra impetus for the establishment and entrenchment of a social constellation – specifically psychopathological domesticity – around a hospital presentation of attempted suicide. The increasing presumption of domestic psychopathology illustrates how behavioural objects become established. The social constellation, the domesticity fabricated by PSWs, appears stable and reliable enough to be presumed around physical injury. Psychiatrists report feeling pressure for a quick discharge of attempted suicides from general medical beds after somatic injuries have been dealt with. In response, the social constellation is increasingly invoked as a reason to keep a patient admitted. Thus the social setting shifts from being produced (laboriously) around an attempted suicide, to being deployed tactically in order to promote and sustain such scrutiny. The object becomes self-confirming, as the more obvious the act's communicative nature become, the more effort is expounded to discover a communicative motive. Finally, the object becomes a socially embedded, increasingly available option for the expression of distress.

The conflicts over admission, management and discharge are 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'. He places dramatic emphasis on the '[t]he irrevocable consequences of mistaken judgment [that] colour every aspect of our handling of the suicidal patient', with special emphasis on 'whether to treat a new patient as an inpatient or an outpatient'. This is a clear intervention in a conflict over scarce resources (beds). One of Kreeger's key arguments concerns the social environment that he, Stengel and Cook work so hard to establish during the 1950s, now 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 relatives in denial

about the attempt, those too weak to support the patient, and those implicated in the cause of the attempt in the first place.[133] Whilst these assessments may push towards inpatient admission (to a psychiatric bed), it is also part of an explicit and concerted strategy against general physicians' pressure to discharge. Clinicians in Leicester bear this out: 'Because of the demand for beds' patient stays are 'generally too short for full psychiatric assessment'.[134]

Bridges, Koller and Wheeler also note serious pressure on resources, but suggest a more amicable resolution. Perhaps because psychiatry is well-established at KCH they are pleased to report that '[c]onsiderable co-operation was obtained from other departments so that many of the inpatient referrals received complete psychiatric treatment in a medical or surgical bed'. However, they complain that they have 'very few psychiatric beds', and that it is 'somewhat unsatisfactory' to use general beds for these patients. They are diplomatic, relating that '[t]here is always understandable pressure from physicians and surgeons for these patients to be transferred or discharged as soon as possible to allow further use of the bed', but resource conflict looms large. In this wider context they argue for a minimum of three days' observation for most patients 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'.[135] Crucially, there are not only practical factors advanced in favour of continued occupancy of the bed (mood assessment and social history-taking), but 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 resolve crises. This is the precise opposite of Kreeger's thesis, but deployed in the same cause. Here the social generation and therapeutic repercussions of an attempted suicide become subtle but effective insulation against discharge pressure from physicians and surgeons.

Kessel's potentially psychopathogenic social constellation works differently again, maintaining a base for psychiatric credibility within the general hospital, but it 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):

> [P]eople 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.[136]

Psychiatric credibility and the claimed necessity for further scrutiny are based on a vision of domesticity created by that very scrutiny. Kessel's 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 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 constellations are substantially sustained by politicking across the well-maintained split between general medical and psychiatric therapeutics. The production of a potentially psychopathogenic domestic space plays a key role in claim-staking in a general hospital environment.

'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 transformation of physical injuries into symptoms of a social constellation means that the latter (social constellation) can be used to explain the former. 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', becoming 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'.[137] Krohn is talking about images and diagrams, but this is a useful concept to explain how referral, PSW interviews and psychiatric scrutiny being 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 (e.g., poisoning), possibly unconscious or semi-conscious. After somatic treatment (possibly stomach washing), practices of referral are required in order to question and assess the patient from a psychological point of view. 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. 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.

It is at this point of mutual constitution – when meanings and pathogenic social spaces are established, to then be deployed to reinforce the scrutiny that produces them – that the object can be considered established. This self-reinforcing process can spread and, to paraphrase Hacking, new possibilities for action become a culturally sanctioned way of expressing distress.[138] However, as has been argued here, this concept of distress is linked to socially directed or communicative behaviour in such a comprehensive way that, in the case of attempted suicide, there is not much value in using one to explain the other. Indeed, using the language of distress to explain a psychological epidemic of anything during the twentieth century begs more questions than it answers, given that distress is constituted at the heart of – and is a conceptual guarantor for – the new project of psychiatric epidemiology.

Notions of 'incidence' – how regularly this phenomenon occurs – are also important. For behaviour 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. A communicative overdose becomes a widely intelligible response to interpersonal difficulties. Thus another shift occurs, exceeding the situations described throughout this thesis, a shift where objects are produced and stabilised, through exclusions and emphases, in fields of enquiry made possible by various techniques and practices. When this 'information is general' (in Kessel's words), people might actually start doing it more often, feeding back further into the epidemic.

Conventional notions of incidence and epidemics need to be radically reconceptualised. The analysis of social phenomena such as this overdosing epidemic through body-counting and statistical compilation and computation are severely limited. Not only do these approaches run

these two stages together, but this collapses the first 'technical' stage into the more simplistic second stage, where more people are able to start acting in newly established, resonant ways.

Concluding thoughts

The neologism 'parasuicide' is proposed in the 1969 letter by Kreitman, Philip, Greer and Bagley. The term is advanced on the basis that the phenomenon is current, important and generally established. In 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.[139]

The neologism is also part of a local effort to refocus the Edinburgh Unit's energies, as it is soon to be explicitly reorganised around parasuicide (in 1971).[140] However, this local context should not obscure the more widespread agreement that a stable and distinctive pattern of behaviour exists. This pattern 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 chapter has shown how a particular vision of the social setting is constructed through a number of specific practices, ideas, assumptions and prejudices. The specifics of the 'social setting' should not obscure the principal point that people in the above studies, presenting at hospitals after having harmed themselves, are not being asked about their internal, emotional states at the time of the overdose, or about their family history of mental illness. They are being questioned about their social setting, their relationships with others, the people with whom they might be communicating – all this in order to make sense of the attempt. The idea of the significance of self-harm, an idea which seems so stable in the 1969 letter ('everyone seems to be agreed'), is to change radically over the next decade, as we shall see in the next chapter. The idea of self-cutting as tension-release is already being argued for by 1969, principally in North America. The link between Britain and North America is further strengthened as both countries loudly proclaim their affinity for neo-liberal economics in the 1980s. The links between the two countries in definitions of self-harming behaviour are also strong and increase in influence throughout

the 1960s and 1970s. Underlying both neo-liberalism and self-cutting is a reading of human nature that is significantly more individuated and self-regulating than what came immediately before; social welfare and social communication give way (unevenly and gradually) to individuated emotional regulation, and eventually to biomedical, neurochemical ideas about self-harm.