Millard C. A History of Self-Harm in Britain: A Genealogy of Cutting and Overdosing. Basingstoke (UK): Palgrave Macmillan; 2015.

Chapter 2 Communicative Self-Harm: War, NHS and Social Work

In 1944, Henderson's and Gillespie's *Textbook of Psychiatry* notes the 'remarkable progress that has occurred in psychiatry in recent years in the teeth of war conditions, and even, to a limited extent, because of them'.[1] The Second World War nurtures and catalyses a large number of reforms and innovations in the thought and practice of British psychiatry. Attending to the psychological casualties of the Second World War generates a huge number of interpersonally focused psychotherapeutic practices. The psychological significance of personal relationships, of adjustment to situations, of communication and social interaction become central to the linked aims of maintaining military and civilian morale on one hand, and returning psychological casualties to service as soon as possible on the other. The link between the social setting and psychological well-being is not generated by the war. However, the war does give an enormous boost to conceptions of what becomes known as the 'psychosocial'.

Of no less import is the post-war settlement, particularly the National Health Service (NHS). Its enormous significance impacts psychiatry in diverse ways. Most important here is inclusion of mental health within the comprehensive service, which enables closer co-operation and referral between the fields of mental and general medicine, vital for the visibility of communicative self-harm. NHS funding removes the financial burden of attempted suicide from voluntary hospitals, detailed in the previous chapter. This results in practically all cases presenting at hospitals to be admitted to general hospital casualty departments. The integration effected by the NHS means that these departments assume a coordinating function. Continuing as places for acute care, they become a gateway to the varied specialisms of hospital medicine (surgery, urology, etc.). Their positions as acute, non-specialist, diagnostic departments means that despite the removal of financial or therapeutic dispute, attempted suicide as communication does not emerge consistently here. There is no sustained psychological scrutiny or follow-up, both of which are necessary for this to materialise. Thus there are two parts to the increased emergence of attempted suicide: a path between different therapeutic regimes, or a space that can encompass them both, and the possibility for sustained, high-intensity psychiatric scrutiny to construct an environment necessary for communicative self-harm. This environment is crucial to the complex intent presumed behind the act, shifting it from the achievement of death and opening up communication as a possibility on a broad scale.

The scrutiny of environment is bound up with the rise of child guidance, and especially psychiatric social work. These emerge with the mental-hygiene movement during the interwar period. Jonathan Toms notes that an important strand of this movement was based on the insight that the mind 'was not atomistic and it couldn't be understood separately from its environment'.[2] Allied with the NHS, psychiatric social work provides a more consistent focus upon the environment and on the health of children. A short film about changes to health care in 1948 states that 'the local council will have a new duty to provide home nursing, health visiting, and home help services ... maternity and child-welfare services will be improved'.[3] The NHS and social work, along with expanded welfare provision, bring the 'social environment' into renewed focus. Communicative self-harm emerges on a national scale thanks to the foundations laid by this settlement. It falls away when this provision is radically renegotiated in the 1980s, with the rise of neoliberal economics. Again, this relationship is not simply causal – in fact it is not really simple in any sense. However, the central idea here is that political and institutional contexts are fundamental to the emergence of clinical, psychiatric concerns: humans make sense of the world with the intellectual and practical resources that resonate with their larger context.

Concern about children is influentially expressed in the burgeoning popularity and influence of John Bowlby's theory of maternal attachment, with emphasis on the psychological importance of the family and on the connection between mental disorder and social problems such as crime and delinquency. This therapeutic approach underpins a pioneering series of attempted-suicide studies in the early fifties. These are carried out in Edinburgh between 1951 and 1955 in an observation ward with historical roots different to those of the workhouse mental block. This Ward for Incidental Delirium (known colloquially as Ward 3) has less focus on security and restraint and more of an entrenched somatic medical focus – specifically around poisoning. The studies carried out in Ward 3 are significant because their findings are underpinned by collaboration between a psychiatrist (Ivor Batchelor) and psychiatric social worker (PSW) (Margaret Napier). The presenting physical injury is transformed into a communicative symptom of a disordered social situation by the investigative practices emerging from this collaborative effort, such as home visiting and follow-up interviewing.

Alongside these studies are a number of contributions by Erwin Stengel, both by himself and in collaboration with a PSW (Nancy Cook) and a psychiatric registrar (Irving Kreeger), including the seminal *Attempted Suicide: Its Social Significance and Effects* (1958). The practice of referral to observation wards is prominent in Stengel's work, as is follow-up interviewing, showing how transfer between acute somatic care and psychological investigation is further developed by PSW practice. Attempted suicide is still significantly associated with observation wards. However, the NHS not only removes financial disputes but also facilitates movement between different therapeutic approaches, helping PSWs and psychiatrists to collaborate on this object, further transforming it into a consistent and credible expression of interpersonal disturbance.

Broader concerns about the young erupt in moral panics over Teddy Boys and rock 'n' roll during the 1950s, more famous landmarks of that decade's cultural history than is attempted suicide. However, these all focus upon the same demographic group: adolescents and young adults. Attempted suicide thus resonates with broader concerns about young people, deviance, delinquency and subcultures. In 1953 the Reverend Chad Varah establishes a service from his London vicarage for people 'in distress who need spiritual aid' and a '999 for the suicidal'. The *Daily Mirror* coins the term 'Telephone Good Samaritans' for the service and it sticks.[4] Concern about the mental, physical and moral state of young people, and about suicide, distress and despair circulate throughout the 1950s, a decade overshadowed on either side by the Second World War and the swinging sixties.

War, therapeutic communities and psychosocial practice

The Second World War provides impetus, resources and fertile soil for the study of the psychological significance of group dynamics and social contexts. Tavistock Clinic psychiatrist John Rawlings Rees is appointed Consulting Psychiatrist to the Army early in the war. He argues that 'out of the peculiar conditions created by conflict and national effort, there seem to have come some things that are of value ... psychiatry has perhaps matured more as a result of war experience than it could have done in five years of peace'. Part of these so-called peculiar conditions is the notion that '[f]rom having a somewhat limited function, psychology became suddenly a weapon of war, a method by which the fighting force could be improved, the interests of the individual better served and the health of the community ... safeguarded'.[5] It seems that the particular demands of total war – chiefly for people to act in the interests of the collective – encourages this maturation or development of psychiatry to take a certain form. The fact that collective martial effort (total war) spawns a focus upon collective or group experiences and dynamics is not coincidental.

But the war is not the whole story. Tom Harrison provides a fine, lucid study of the Northfield experiments, perhaps the most famous wartime studies of the psychology of groups and group dynamics. He traces a sense of psychosocial awareness through the crowd theories of Gustave LeBon, Wilfred Trotter's ideas on herd instincts and William McDougall's concept of the group mind – ideas proposed in the late nineteenth and early twentieth centuries. He also mentions the ideas of Sigmund Freud, W.H.R. Rivers, Melanie Klein, Ronald Fairburn, Joshua Bierer and the field theory of Kurt Lewin. Finally, he mentions two prominent health and mental-hygiene experiments from the interwar period: the Hawkspur Experiment in Essex, and the Pioneer Health Centre in Peckham. This certainly seems like 'an intellectual primeval soup' that ferments towards group awareness.[6] However, tracing influences and precursors in a rush of names and conceptual shorthand can lead to confusion. Presented here is a brief appraisal of how the Emergency Medical Service enables the integration of psychological scrutiny into general hospital practice. Later in this chapter we shall see how it also leads to increased prestige for psychiatric social work. Thus, can we see how the war catalysed the development and acceptance of specific threads in the story of communicative self-harm.

The war is clearly seen to impact upon the integration of mental health perspectives into general hospitals. James M. Mackintosh, professor of preventive medicine at Glasgow writes during the war about how out of the emergency hospital service has developed 'a growing emphasis on the mental health aspect of general hospital treatment'. He includes psychiatric social work in this, adding that for the treatment of long-stay (surgical or medical) patients in general hospitals '[t]he psychiatrist and the mental health social worker should be in the background, ready to advise on cases of special difficulty'.[7]

War conditions are seen as having wide-ranging impacts on the functions of general hospitals. This involves consideration of social and psychological factors as well as physical ones.

> Since the beginning of the present war there has been steady although limited progress in the conception that the general hospital has a specific function in restoring the sick to health and working capacity. This involves early assessment not only of the patient's physical condition and ultimate prognosis, but also of his mental attitude, his

> family background, and his suitability for the work in which he was previously engaged, all psychological as well as industrial problems.[8]

Here we can see that the increase of psychological scrutiny in general hospitals in the early twentieth century (traced in the previous chapter through the Mental Treatment Act and observation wards) is developed and encouraged by the Emergency Medical Service in wartime.

Harrison notes that military life interacted with psychoanalysis and social theory, a triumvirate that he claims 'led inevitably to the experimentation with group therapy on a wide scale within the British and other armies'. Whilst contesting that this was in any way inevitable, we can agree that there is certainly a productive relationship between these three factors. He goes on to say that 'it became increasingly obvious, as the war progressed, that group therapy was a logical extension of army life. This, allied with the large number of men requiring help and the relatively few staff available, led inevitably to widespread experimentation with the new technology'.[9] If we again downplay the inevitability, Harrison here shows how the practical conditions of army life might make groups obvious in an intellectual sense, and the resource shortages make group therapy attractive in a much more mundane, but no less powerful way.

Harrison describes this focus upon social networks and group dynamics in wartime practice in terms of a discovery of pre-existing needs. He is committed to the insights of therapeutic communities as true (obvious, inevitable), rather than as emerging as a particular, historically specific perspective. Nevertheless, he argues that

> the exigencies of army life ... provided the final link in the chain, and whether group therapy would have ever gained such recognition without this fillip is uncertain. Clearly, there were individuals promoting this form of activity before the war; but they were largely operating in isolation and in a more or less charismatic manner. The war led to ordinary psychiatrists experimenting with these new ideas.[10]

From this we can see how wartime conditions interact with pre-existing ideas and practices, fuelling the development of these socially focused insights. Rather than being inevitable, they rely upon specific contexts in order to be able to emerge as increasingly obvious or self-evident.

The NHS and psychological scrutiny during the 1940s and 1950s

Building upon the Emergency Medical Service, the NHS brings different specialist outlooks into a new, more connected relationship with each other. In the case of psychiatry, the Board of Control (the government department responsible for mental health care until 1959) is brought into the NHS, having unsuccessfully pushed for a separate administrative mental health care structure.[11] Thus the potential for crossover between mental and general medicine is much more widely available than being simply focused upon observation wards. A new combination of specialisms brings about new clinical objects, and observation wards are well-placed to build upon this, playing a central role throughout the 1950s. The NHS is also the first step in broadening the new field, combining acute-physical and psychosocial visibility – on a national scale – in general hospital casualty departments. For various reasons, these departments cannot quite sustain this, but play an important role in the growing visibility of this phenomenon.

The establishment of the NHS is widely viewed as an important step in the integration of psychological and general medicine. The final chair of the Board of Control, Walter Maclay, and epidemiological psychiatrist, John Wing, both cast the founding of the NHS as an intermediate stage between separated and integrated mental and general medicine.[12] The end point of this process (for Maclay) is the Mental Health Act 1959, covered in Chapter 3. This integration impacts upon the visibility of attempted suicide.

In 1947, after the passing of the NHS Act but before the 'appointed day' of inauguration in 1948, clinicians at the Withington Hospital in Manchester relate the appointment of 'a visiting psychiatrist' allotted around twelve beds'. This non-observation-ward method of embedding psychiatric scrutiny in a general hospital setting has consequences for the visibility of 'attempted suicide': 'Seventeen patients were admitted after attempts at suicide by various methods, the largest group being six cases of barbiturate poisoning'. They are even more explicit about the changes in terms of visibility: 'Very many patients who would formerly have been treated only by physicians are now recognised as requiring psychological examination'.[13] However, this experiment is very small-scale.

By April 1950 in Manchester it is decided that to achieve progress in psychiatry, services should no longer be based around asylums, in direct conflict with recommendations from the local psychiatric specialists. John Pickstone argues

that this is driven by the idea that services based in remote mental hospitals with peripheral general hospital clinics 'will only serve to divorce the diagnosis and treatment of mental disorders still further from the broad stream of general medicine'. Instead 'new psychiatry posts would be attached to district general hospitals'.[14] Thus in the early years of the NHS, integration is achieved by creating administrative structures that minimise the space between mental medicine and the general hospital. Of course, explicit attempts at crossover unavoidably reassert difference. This is exacerbated by the Board of Control; George Godber, chief medical officer between 1960 and 1973 recalls that that 'largely at the insistence of the Board of Control', all mental hospitals and mental deficiency hospitals had separate management committees. He claims that '[t]here was no reluctance locally to having mixed management groups – it was the Board of Control's influence'.[15]

A&E Under the NHS

Casualty departments are important under the NHS, as the reception (and sorting) centre for all emergencies, including attempted suicide. However, Henry Guly notes that '[b]etween 1948 and 1960 there was little of substance in the medical literature describing casualty services'. Guly notes that it is even argued that A&E does not qualify as a specialism at all due to its generalised role, covering emergency care of all kinds.[16] A&E is a particularly unfashionable area for doctors of the 1950s, and it remains over-stressed, understaffed and under-funded today.[17] In 1956 T.G. Lowden, a consulting surgeon working in Sunderland, writes a series of three articles in the *Lancet* entitled 'The Casualty Department' (following his book of the same name published the year before). He opens the series comparing casualty to a secretary's office, calling it a 'coordinating mechanism on the medical side', often performing administrative rather than strictly clinical work.[18] This coordinating role, a key part of the comprehensive service under the NHS, is the practical arrangement that removes the disputes over the appropriate place to take attempted suicides. For A&E to become the 'given' place to take an attempted suicide requires the NHS.

In Lowden's *The Casualty Department* (1955), attempted suicide is a distinct concern. He describes a coma patient sent in by her G.P., who regains consciousness on the way to hospital and shows no signs of illness in casualty. She is discharged home with a future G.P. appointment. However, later that evening she takes a large overdose of the same drugs and the casualty officer is criticised for not admitting the case. Whilst Lowden is sure that there is 'no reasonable basis for the criticism', this example shows that attempted suicide achieves visibility (and causes anxiety) in casualty because it is read as a genuine attempt to end life – an attempt that might be repeated more successfully at any time.[19] This concern is similar to concerns over renewal in the police watching disputes.

Thus, despite the integrative shift of the NHS, Lowden's position in the 1950s is both cautious and clear – the divide between mental and physical therapeutics remains central to his thinking. He argues that because of coroners' almost invariable reference to 'mental instability' in cases of suicide, '[a]ttempted suicide should therefore logically be an indication for psychiatric treatment ... and all such cases should be treated at a mental hospital, unless the medical or surgical condition is so great that general hospital admission is necessary'. The mental hospital is the most appropriate place for an attempted suicide, so long as medical or surgical treatment is unnecessary, a position that evinces a clear psychological/ general medical differentiation. He acknowledges that mental hospital admission is not often effected, so 'cases of attempted suicide who do not require admission for their organic lesions often call for a decision on disposal'. Again, attempted suicide is an issue due to the dual concerns of organic lesions and emotional states, the recurring poles of soma and psyche:

> Much depends upon the circumstances, and particularly the emotional state of the patient. Young girls who make a half-hearted attempt to commit suicide because they have misbehaved and missed a period may often be returned to the vigilance of their parents.[20]

Some small, highly gendered fragment of what becomes the attempted suicide stereotype emerges at a casualty department. Such a case is characterised as falling between therapeutic regimes: unsuitable for mental hospital admission and unsuitable for admission on account of any organic injuries. Thus, nothing much can be done, and the patient should be sent home. The therapeutic approaches are still too separate; different arrangements for psychiatric scrutiny are required in order to register a need for any kind of extended surveillance or investigation. Whilst the NHS is a key step in integrating therapeutic regimes, and A&E becomes the single site for all emergency admissions, a socially directed attempted suicide does not appear as a credible research object here. The scrutiny available at A&E is not sufficiently psychological or intensive to fabricate a credible social setting around the presentation of attempted suicide; the sorting of casualty seems to emphasise the separation of therapeutic regimes rather than bringing them together.

However, alongside A&E there is a continuing link between observation wards and attempted suicide under the NHS. In 1949, the above-mentioned Withington Hospital (Manchester) experiment shows how at first the nurses 'were anxious to get every attempted suicide out of the hospital and into the observation ward'.[21] The success of the experiment undercuts the nurses' attitude that the observation ward is the only place for attempted suicide, but their reported first reaction exposes the traditional association. Ivor Batchelor argues in 1955 that in the case of attempted suicide '[w]here possible, immediate admission to the mental observation ward of a general hospital is the ideal arrangement'.[22] Batchelor's observation ward studies are considered next.

Ward 3 of the Royal Infirmary of Edinburgh

Ivor R.C. Batchelor publishes eight articles on 'attempted suicide' between 1953 and 1955, based on clinical work at the Ward for Incidental Delirium (Ward 3) of the Royal Infirmary of Edinburgh. He serves as a neuropsychiatrist in the Royal Air Force Volunteer Reserve during the Second World War and subsequently joins the Royal Edinburgh Hospital under D.K. Henderson.[23] Henderson has been mentioned as co-author of an influential textbook, but he is much more significant than that. Professor of psychiatry at Edinburgh between 1932 and 1954, he is second only to Aubrey Lewis as an influential mentor to twentieth-century British research psychiatrists. It is said that Lewis used to refer to Henderson 'with a combination of sincerity and irony ... as: "The most distinguished psychiatrist in the United Kingdom"'.[24] Batchelor remains at Edinburgh for nine years, leaving for Dundee in 1956, and in January 1958 takes part in a published discussion on the 'Legal Aspects of Suicidal Acts'.[25] Erwin Stengel argues that Batchelor is 'the leading psychiatric authority' on attempted suicide in Scotland.[26] He collaborates on three of the eight articles with Margaret B. Napier, senior PSW based at the Edinburgh Hospital for Nervous and Mental Disorders.

These studies emphasise the role of so-called 'broken homes' and alcoholism in attempted suicide, the two foundations of the socially focused aetiology they construct. They are equivocal about the formal appeal character, doubting whether it is always present. They worry that overemphasising this point might lead to an underestimation of the danger involved.[27] Before these studies are analysed more closely, their national and institutional settings are described from two angles: the potential for crossover between psychological and general medicine, and the provision of high-intensity, environment-focused psychological scrutiny. These concerns, central to the analysis of observation wards in the previous chapter, remain vital here.

Suicide and attempted suicide are not crimes in Scotland, a situation described in more detail in Chapter 4, which focuses on a research unit at Ward 3. The lack of legal sanction in Scotland is regularly invoked in the late 1950s by those campaigning for decriminalisation south of the border (part of the growing post-war legal interest in suicide covered in Chapter 3). The documents produced in the lead-up to decriminalisation bring to light a standing arrangement in Scotland of much relevance. The Home Office enquires about Scottish hospital practices in 1958 and discover 'a standing rule that patients who have attempted suicide are seen by a psychiatrist whilst still under treatment'. The history of this rule is not given. However, the general situation in Scotland is described as 'neither clear nor altogether re-assuring'.[28] After the change in suicide law , the Department of Health for Scotland again states (in January 1962) that '[t]here are at present standing arrangements at Scottish Hospitals for the psychiatric examination of patients who have attempted suicide and have been taken to hospital because of their injuries'.[29] Thus there are established arrangements in Scotland for focusing some form of psychiatric scrutiny (presumably from visiting consultant psychiatrists) upon patients presenting at general hospitals and read as having attempted suicide. However, only one Scottish site appears to produce studies of this phenomenon during the 1950s.

An idiosyncratic, contested observation ward

During the early 1950s Ward 3 is under the administration of Senior Psychiatric Registrar James Kirkwood Slater. Neil Kessel and Norman Kreitman both acknowledge the centrality of this ward to their respective work on 'self-poisoning' and 'parasuicide' in the 1960s and 1970s. The ward facilitates consistent psychological scrutiny of patients presenting with a somatic injury. Kessel comments in 1965 that there are 'auspicious circumstances' for studying this particular subject in Edinburgh, because for 'many decades the Royal Infirmary has had an "incidental delirium" ward for patients who required overlapping general medical and psychiatric care'.[30] Kreitman recalls 'an excellent clinical service' and an 'ideal research base'.[31] The two parts of the transformation appear explicitly: overlapping therapeutic regimes and the possibility for high-intensity scrutiny (psychiatric research). The ward has some fame at Edinburgh's medical school, known among 'countless numbers' of graduates and called a 'unique and traditionally hallowed charge in the Royal Infirmary of Edinburgh'. Much of what follows is based upon an unpublished 1962 memorandum

(most probably written by Slater) stored at the Lothian Health Board Archives in Edinburgh, the best history of the ward available.[32]

The ward begins the twentieth century as a place to house noisy or otherwise difficult medical patients, a provision then extended to those brought in by police (including alcoholics with delirium tremens). This is further extended, after 1918, with the admittance of prisoners in need of medical procedures. Finally, at some unspecified point, those in authority discover that Ward 3 is 'admirably suited to their difficulties about failed suicides and thus followed other forms of poisoning, including the accidental ones'.[33] (Note the elision of attempted suicide with poisoning.) These difficulties are therapeutic and practical rather than legal, as attempted suicide is not a crime in Scotland. The ward's purpose significantly fluctuates over the century, but still fits into the pattern of associating attempted suicide with observation wards.

The memo exhibits anxiety over the use of coercive measures, specifically locked doors: '[T]his ward alone in all our hospitals is under lock and key. The modern view resents this as an anachronism'. The shorthand of the 'modern view' includes the shift towards promoting equivalence between mental and general medicine. However, too close an equation with observation wards is rejected by Slater, who argues:

> No right thinking person would deny that a modern hospital must provide accommodation for psychiatric observation and in the absence of this the psychiatrists have consistently cast covetous glances at Ward 3, but equally their claims have been defeated by the vote of the consulting staff who have recognised that, while a special opinion is likely to be sought, not infrequently, yet, in the first instance, every single admission to this charge was a medical or surgical problem and that the psychiatric opinion was needed if at all at a later stage.[34]

A number of things require comment in this long, dense sentence. Firstly, that Ward 3 is coveted by psychiatrists, who desire facilities for psychiatric observation. This implies that the ward must fulfil this function, at least in part. Slater resists these claims by asserting the primacy of non-psychological therapeutics (the claim that every single admission is a medical or surgical problem). He admits that psychiatric input is valuable in the appropriate place, and is anxious to stress that the current liaison/referral system works well: 'For many years a most happy arrangement along these lines has been in operation to mutual advantage'.[35]

Slater is most concerned to preserve the overall control that he believes would be ceded to psychiatrists were Ward 3 to become simply an observation ward. This fear emerges implicitly in his proposals to divide the ward 'into three easily identifiable categories' comprising a psychiatric and psychological observation unit, a poisons unit and a miscellaneous ward, including medical care of prisoners. He proposes a link between a psychological observation unit (under the sole responsibility of the professor of psychological medicine) and a poisons unit directed by a physician, assisted by the director of anaesthetics, the kidney unit and others.[36]

Even though observation wards are substantially mixed in their therapeutic capacities (mainly by association with general hospitals), the psychological aspect is seen by Slater as preeminent; their full title is of course mental observation wards. The differentiation of therapeutic regimes is clear, as he concedes full authority to the professor of psychological medicine over the hived-off observation ward section, and brings in some very somatic therapeutics for the poisons unit (which he sees as far more central to the identity of Ward 3) with anaesthetics and kidney specialists. He is anxious that the ward is not swallowed up by psychological medicine, and that the psychiatrists remain involved on a referral basis only. Indeed, he is explicit about psyche–soma separation, indicating that the observation unit and poisons unit are 'quite separate charges although inter-related'.[37] To borrow a phrase from Ian Hacking, 'this is claim staking with a vengeance'.[38]

Stengel and Kessel stake counter-claims from the psychiatric side. Kessel argues in 1962 that the poisoning unit at Ward 3 'serves as a psychiatric sorting and disposal unit for cases of attempted suicide far more effectively than the traditional English observation ward, which dares cater only for those who have not rendered themselves unconscious or hurt as a result of their actions'.[39] Whilst Kessel cedes the 'poisoning unit' name, his focus is on psychiatric sorting and disposal, which is complemented by somatic therapeutics. Stengel claims in 1963 that 'in Edinburgh [attempted suicides] are admitted to an observation ward where emergency services for resuscitation are available – which is not the rule in psychiatric observation wards elsewhere'.[40] The ward is envisaged primarily as a (psychiatric) observation ward, with somatic therapeutics attached, rather than a poisoning unit with psychological scrutiny available on demand. The uneasy co-existence of psychiatric and somatic therapeutics is exceptionally well illustrated. Slater's

proposed reforms do not happen, and this productive tension between therapeutic regimes continues, enabling the transformations involved in attempted suicide as a communication.

In both Stengel's and Kessel's accounts, the Ward's somatic therapies provide opportunities to scrutinise patients arriving at hospital with somatic injuries. In an account from the 1980s, historian E.F. Catford highlights the extensive role of social workers in this scrutiny, claiming that they 'play an important role and may find it necessary to keep in touch with patients of the [Poisoning Treatment] Centre and their families for a long period'.[41] The connections between social workers, families and post-war psychiatry are extensive and significant.

Politics, PSWs, and child guidance

As well as the institutional base of Ward 3, Batchelor's and Napier's attempted-suicide studies are significantly influenced by and accessed through the practices of psychiatric social work. This professional group are exceptionally important in bringing the social setting to bear in various ways. The roots of PSWs lie in mental after-care and the child-guidance movement. Vicky Long shows that in the late nineteenth and early twentieth centuries 'the Mental After Care Association deployed lady volunteers to visit its charity cases in their homes or places of work to check on their progress and resolve any difficulties'.[42] Noël K. Hunnybun, senior PSW in the Children's Department at the Tavistock Institute, also mentions this association in his history of PSWs.[43] Jonathan Toms argues that there exist four organisations at the heart of the mental-hygiene movement in the interwar period: the Central Association for Mental Welfare, the National Council for Mental Hygiene, the Child Guidance Council and the Tavistock Clinic . All these groups, he claims: '[P]romoted social work as an important ancillary profession necessary for good mental hygiene. In particular they supported the creation of a profession called "psychiatric social work"'.[44]

John Stewart and Hunnybun both agree that the development of PSWs is intimately bound up with child guidance.[45] Hunnybun traces the profession back through concerns expressed in Cyril Burt's *The Young Delinquent* (1925), which emphasises 'the importance of studying the child in relation to his family and social background'.[46] Concerns with 'families' and 'social background' are absolutely crucial to PSWs (and to attempted suicide), and the profession emerges from a tangle of mental aftercare, mental hygiene and child guidance.

On an institutional level, the Tavistock Clinic's department for children opens in 1926 and the Commonwealth Fund of America finances the London Child Guidance and Training Centre, established in Islington, North London, in 1929. This same fund provides start-up money for the Association of Psychiatric Social Workers that year. Child guidance grows substantially during the interwar period. John Rawlings Rees is in no doubt about the significance of this for social-psychological perspectives. He claims that during the interwar period:

> Child psychiatry became established and never looked back; probably it is in fact the most important contribution to health that psychiatry has made in this century. The social worker and the psychologist began here to demonstrate how great a contribution they had to make ... we owe much of our growing interest in the sociological and psychological aspects of our work to children's psychiatric clinics.[47]

From 1936 John Bowlby works at the London Child Guidance Clinic. Whilst there he is 'strongly influenced by the psychiatric social workers' casework approach and theorisation of emotional relationships in the family'.[48] Bowlby's most influential concept is 'maternal deprivation', which locates the potential for psychopathology in mother–child attachments.[49]

This reconfigures the crux of the parent–child relationship away from the intricate fantasies, envies and anxieties of orthodox psychoanalysis, focusing on 'real life events': 'Where most psychoanalysts assume that neurotic symptoms originate from the patient's inner world of fantasy, Bowlby remained firmly convinced that traumatic events in real life were more significant – not only actual separation and loss, but also parental threats of abandonment and other cruelties'.[50] This constitutes a crucial emphasis on the social origin of psychopathology.

As well as the establishment of the Tavistock's Child Guidance and Training Centre, the year 1929 sees the London School of Economics establish the first PSW training course for social-science graduates. The universities of Edinburgh (1944), Manchester (1946) and Liverpool (1954) follow suit.[51] Prolific PSW Elizabeth Irvine notes that PSWs can join the local authority mental-health services after these are reorganised following the Mental Treatment Act 1930, and numbers rise from eight to twenty-six between 1951 and 1959. This 1950s movement from mental hospital to local authority provides 'an opportunity to return to the focus on the patient in his family which had been eroded in many mental hospitals'.[52] Felix Post – who conducts studies around the same time as Stengel (early 1950s)

and on the same London ward – also becomes involved with the role of the family in mental illness, citing H.B. Richardson's *Patients Have Families* (1945) as a 'pioneer work'.[53]

The PSW training courses in Edinburgh are based on the Department of Social Studies, unlike those at Manchester and Liverpool, which are part of the respective Departments of Psychiatry. Even so, it can be assumed that the Meyerian influence of D.K. Henderson over psychological medicine at Edinburgh makes it a conducive place for PSWs to work. This enables them to flourish, for whilst '[l]ip service was paid to Adolf Meyer's more global picture ... only a minority of psychiatrists seemed to take this seriously in practice. [Those who did] were the best friends of the PSWs, and valued their support in demonstrating the ... tensions and conflicts in the family and social situation'.[54] PSWs are again intimately concerned with access to family and social conflicts in the aetiology and course of mental illness. Eileen Younghusband is perhaps the single most influential person in the field of social work in Britain in the twentieth century. In her two-volume retrospective of British Social Work published in 1978, she notes the 'complementary role' of social work in the treatment of mental disorder, stemming from wider acknowledgement during the 1950s of 'the profound influence which the family and social environment had on the well-being and social functioning of mentally disordered people'.[55] Ideas about 'the family' and 'the social' are of great importance.

As noted, the engagement of British psychiatry with the Second World War generates a huge number of interpersonally focused psychotherapeutic practices. It is also argued that a key factor in Bowlby's work is becoming influential – both in the mental-hygiene movement and upon government policy – is the onset of war.[56] The war reproduces, institutionalises and catalyses many of these interwar insights. Maxwell Jones, pioneer of the therapeutic community, states that '[t]he war years were my salvation', as his work at Mill Hill on effort syndrome provides the basis for his first such experiment in this kind of therapeutic organisation.[57] Rees relates in 1945 that it 'often occurred to me during this war how adequate a machine this child guidance team has been. Quite unconsciously the organisation of the War Office Selection Boards ... has turned out to be on exactly parallel lines. Here also there is a team: a psychiatrist, a psychologist, and the regimental officer whose function is more sociological than military'.[58] Here child guidance, the team approach and the war are run together as a powerful innovation. Instead of simply treating symptoms in order to return men to the front lines, Wilfred Bion at Northfield sees the army psychiatrist's task in terms of social adjustment, an effort to 'produce self-respecting men socially adjusted to the community and therefore willing to accept its responsibilities whether in peace or war'.[59] Tom Main, describes 'therapeutic social fields' through which patients would progress on their journey back to adjustment and health.[60] The language of community, social field and adjustment pervades these wartime endeavours to treat mental disorder.

Kenneth Soddy's booklet, *Some Lessons of Wartime Psychiatry* , recommends that a 'psychiatric social service' be established to deal with mental disorder, mental deficiency and maladjustment.[61] During the war, James Mackintosh, professor of preventive medicine at Glasgow, argues that '[t]he expected result of this [wartime] work is that local authorities ... will desire to place the whole scheme on a more permanent footing and make their own appointment of a psychiatric social worker'.[62] Invigorated and validated by the war, the concerns of (psychiatric) social work, centred upon the family, the child and adjustment to the social setting go from strength to strength as part of a broad political project in post-war Britain.[63] Influential studies from Aubrey Lewis's Social Psychiatry Research Unit by George Brown, Morris Carstairs, John Wing and others build from this position of strength, focusing upon the role of the family in the course and recovery rate of conditions such as schizophrenia.[64]

Nikolas Rose describes this post-war project in terms of 'minimizing social troubles and maximizing social efficiency' and notes that psychiatric social case work, through ideas about familial relations, is able to access and intervene upon 'the internal world of the home ... in a new way'.[65] Mathew Thomson argues that social workers are seen during the 1950s and 1960s as 'shock troops' of a movement to spread psychological and psychiatric understandings of self and surroundings, with 'an ability to reach into the home'.[66] Eghigian, Killen and Leuenberger describe a post-war 'new wave of state interventionism ... directed at women, children, and families'.[67] The goal of all this prescription, intervention, counselling, casework, psychological analysis and measurement is to produce what Rose has called the 'responsible autonomous family',[68] a nuclear, private, productive unit comprising well-adjusted and physically and psychologically healthy citizens. This is the 'social setting' with which 'self-poisoning as communication' corresponds. Jonathan Toms has recently complicated this picture, drawing out the tensions and contradictions in this view of the family and the authority in vested in it. He traces a shifting dialectic of family authority, always containing the seeds of its own disruption, from Samuel Tuke's moral treatment at The Retreat in York in the nineteenth century, to modern psychiatry, via the mental hygiene movement and 1960s anti-psychiatry.[69]

Governmental concern with increasing the number of social workers is noted by Younghusband in 1951, who points out that the Cope and the Mackintosh committees are considering 'the supply and demand, recruitment and training of almoners, and of psychiatric social workers and other social workers in the mental health service'.[70] She is famously associated with the Younghusband Report (1959),[71] which leads to the establishment of the National Institute for Social Work Training (1961) and the Council for Training in Social Work (1962).[72] Explicitly political intervention is also noted by Richard Titmuss in his lecture to the 1961 NAMH Annual Conference. He notes that '[n]umerous Royal Commissions and committees of enquiry have discovered in recent years the virtues of the normal social environment – or as near "normal" as possible'.[73] This is key in the wider project of constituting Rose's 'responsible autonomous family', where this family is 'bound into the language and evaluations of expertise at the very moment they are assured of their freedom and autonomy'.[74]

PSWs are an obvious expression of this psychologised turn towards 'the social' as well as being key instruments in the development and increasing ubiquity of such perspectives. In 1951 Aubrey Lewis claims that 'until comparatively recently explicit concern about these matters was rare ... Times have changed. The psychiatric social worker is an essential member of the mental hospital or clinic staff'.[75] Younghusband calls for a new type of social work with 'a social frame of reference, a fuller recognition of the complexity of human motivation and behaviour, and particularly of family and social interaction'.[76] It is startling just how far Younghusband's general description of developments during the 1950s maps onto the object of attempted suicide being tracked here, especially the complex motivation, and social frame of reference. Again, this effort – an intervention to manage, treat and regulate the social setting in targeted ways – stands in stark contrast to the shrivelled (or streamlined, depending upon your perspective) social concerns of the British state post-1980s, after privatisation and an enduring rhetoric of self-reliance (see Conclusion).

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

The potential for access to both psychiatric and general medical therapeutic approaches at observation wards (as well as a casual association with 'attempted suicide'), meshes with a broad turn to psychosocial explanations and interventions during the early post-war years in Britain. However, it is not simply that the mixed scrutiny of observation wards is complemented by the psychosocial turn, but that PSWs are increasingly attached to such wards. In 1937 it is noted that '[t]he social worker investigated the history of many of these [observation ward] cases, often interviewing friends or relatives in their own homes, so that a better idea of the domestic conditions could be obtained'. It is also claimed that observation wards 'have the closest contact with the relatives'.[77] This is a space where a vision of the family or domesticity is likely to be brought to relevance and prominence.[78] In 1940 the observation ward's 14-day period of detention is described as an opportunity to have the patient's history and background investigated by 'that essential member of the unit, the psychiatric social worker'.[79] Hunnybun includes the observation ward as a potential setting for PSWs working with adults, adding with some satisfaction that PSWs are gaining in prestige and wider recognition.[80]

The PSW contributions in Batchelor's and Napier's attempted-suicide studies are described as carrying out follow-up, collecting social data and obtaining data from the families.[81] The arrangements denoted by follow-up comprise

> personal re-examination of the patient, or by interviewing the nearest relative or other responsible and informed person. In six cases a psychiatric social worker in another part of the country made a home visit for us; in two cases we got a written report from the individual's general practitioner; and in two further cases a written account from another reliable informant.[82]

A significant proportion of follow-up is carried out through home visits. John Stewart emphasises 'the centrality of the home to child guidance and the part therein of the psychiatric social worker' during the interwar period, and that 'through the medium of the psychiatric social worker' child guidance becomes less focused upon the child as an individual, with more emphasis upon 'the child in its domestic setting'.[83] Indeed, sometimes '[s]ocial workers sought to visit the home even before a clinic visit'.[84] Bridget Yapp, co-author of *An Introduction to Child Guidance* (1945) with Mary Burbery and Edna Balint, claims that the 'child's difficulties cannot be understood without the fullest possible knowledge of the circumstances of his life, including the sort of home in which he lives'.[85] PSW Moya Woodside uses extensive home visiting when collaborating with psychiatrist Eliot Slater on *Patterns of Marriage* (1951) which investigates 'assortative mating' using hospitalised soldiers. Woodside is 'wholly responsible for the field-work. In nearly every case a visit is paid to the soldier's home'.[86]

The second practice – collecting social data or the social history – enables psychiatrists' reliable access to the social setting, and Stewart notes that '[p]sychiatrists appreciated such "social history"'.[87] In this, much weight is attached to 'unsatisfactory parent-child relationships in the first months and years of life', and 'the social and cultural background of the patient'.[88] The influence of mental hygiene and child guidance is clear. Finally, extended interaction with relatives is seen as significantly new in the 1950s. Irvine mentions a 'traditional concern with families', but also that '[t]his kind of work presented new technical problems. Social workers trained mainly for the individual interview ... then had to deal, in conflicted family situations, with the anxieties and rivalries aroused in every member by an outsider's private contact with every other'.[89] Thus PSWs utilise new techniques when rendering the patient's social constellation, home and domestic background.

Looking at these practices and intellectual frameworks in a more abstract and analytical way, we can see how the presenting problem is subordinated to a social constellation – the problem is recast as a symptom of disordered interpersonal relationships. In 1949 John Bowlby argues that 'more and more clearly ... the overt problem which is brought into the clinic in the person of the child is not the real problem; the problem which as a rule we need to solve is the tension between all the different members of the family'.[90] Toms has many examples of this shift in child guidance: Tavistock psychiatrist Dugmore Hunter writes in 1955 of children being forced into illness by parents avoiding their own problems, and psychiatrist Jack Kahn describes in 1957 the 'maladjustment funnelled into [a child] by the group tensions of the family'.[91] This kind of shift, from the presenting problem to the (supposed) real issues of domestic setting, family relationships and social psychopathology, is precisely the shift that underpins ideas of communicative self-harm.

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

In Batchelor's and Napier's studies, the combination of observation-ward scrutiny and PSW practice is made meaningful through the conceptual apparatus of John Bowlby, which, as noted, roots adult mental disorder in real life (as opposed to symbolic/fantasy) traumatic experiences of loss and separation in infancy. The opportunities for psychiatric scrutiny of physically injured patients and for access to a social, interpersonal, domestic background, are guided by the concept that childhood emotional deprivations feed into present psychopathology. Batchelor and Napier explain the attempted suicide as a frustration reaction, largely rooted in a pathogenic broken home in childhood. The intent or purpose of the attempt is particularly complicated because this principal aetiological factor (the broken home) is in the distant past compared to the attempt. An emphasis on social history over social precipitants is evident, but there is significant awareness of the social repercussions of attempted suicide.

The key sample behind their studies is the 200 consecutive cases of attempted suicide admitted or transferred to Ward 3 between 1950 and 1952. (It is notable, given the idiosyncrasies discussed above, that Batchelor and Napier call Ward 3 an 'observation ward' without qualification.) This sample provides many sub-populations for analysis – such as elderly, psychopathic, or alcoholic patients, and those known to have attempted suicide more than once. Of most interest here are the two studies that use the entire sample. 'Broken Homes and Attempted Suicide' (1953) and 'The Sequelae and Short-Term Prognosis of Attempted Suicide' (1954) constitute an initial analysis and one-year follow-up, respectively.

The opportunity for mixed therapeutic scrutiny emerges in the claim – advanced with some pride – that every patient is 'thoroughly assessed from the psychiatric, physical, and social aspects' before discharge, and thus any decision is taken 'on the basis of considerable knowledge'. Their liberal discharge policy for these cases is cast as exceptional: 'It might well be unjustifiable to dispose similarly of a group of attempted suicides who had been more superficially examined'.[92] The necessity of all three assessment areas – psychiatric, physical and social – is repeated in 'Management and Prognosis of Suicidal Attempts in Old Age': 'the physician, psychiatrist and psychiatric social worker should collaborate'.[93] This shows that as well as the mixed psyche–soma scrutiny, the 'social' is just as important. They emphasise 'how necessary it is in cases of nervous and mental illness to understand and to treat the patient in his social context'.[94] The crucial point here is that Ward 3's provision of psychiatric and social scrutiny has the potential to transform the significance of a patient who arrives at hospital presenting with a physical injury. This injury is read as a consequence and symptom of past emotional deprivation.

Social constellations, broken homes and Bowlby

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

> a small number, about 5% of the total group of 200, improved their social positions as a result of their suicidal attempts. If their acts were attempts to manipulate the environment in a direction favourable to themselves, they seemed to achieve that purpose ... A similar small proportion of the group worsened their positions.[95]

This is a present social context, the aftermath of the 'attempt'. Charting these reverberations (from clinical, hospital-based samples) is acknowledged to be difficult. They admit that only the most obvious or extreme consequences could be discovered, and that they 'know nothing of what had been for the meantime repressed successfully, but which may later have a traumatic influence'. They are, however, 'impressed by how frequently the suicidal attempt had made no great commotion in the family group'.[96] This is 'the social', accessed through interviews with relatives and families. A presenting physical injury is transformed into a psychosocial event through information provided (with some difficulty) by a PSW.

The notion of a present-centred appeal – with explicit acknowledgement of Stengel's first publication on the subject from the previous year (discussed below) – is downplayed. Batchelor and Napier do acknowledge that many patients bring attention to themselves through their actions, and gain treatment as a consequence. They understand such a present-centred appeal through a notion of temperament, claiming that this is most often the case for 'temperamentally unstable individuals chronically in conflict with their society'. Whether this temperamental instability is due to developmental issues or innate qualities is left unsaid, but its significance is downplayed: 'It is doubtful if it is an element in all suicidal attempts'.[97]

Batchelor and Napier subordinate present conditions or precipitants to the idea that a broken home in childhood is more significant. Throughout the articles it is repeatedly mentioned as a crucial factor. The opening of 'Broken Homes and Attempted Suicide' (1953) draws explicitly upon Bowlby to claim that the 'social and medical importance of "broken homes" in affecting adversely the mental health of the children nurtured in them is now widely recognized'.[98] They note that Bowlby's *Maternal Care and Mental Health* stresses 'the supreme importance of mother love in infancy and early years', emphasising that 'a broken home in the individual's childhood is aetiologically of considerable importance'.[99] However, they do not quote Bowlby's assertion (in the same WHO report) that 'the concept of the broken home is scientifically unsatisfactory and should be abandoned ... In place of the concept of the broken home we need to put the concept of the disturbed parent–child relationship'.[100] Contrary to Bowlby's attempts to throw out the concept of the broken home, Batchelor and Napier seek instead to preserve and refine it, using broader samples allied with a precise definition.

They extend the concept of 'maternal deprivation':

> The traumatic effects of a lack of mother-love in childhood are nowadays everywhere recognized. Our findings also seem to emphasise the importance of a distortion or lack or absence of paternal influences in childhood. In a patriarchal society, the father is the figure in the home probably of chief importance ... In investigations of the broken home situation there has been a tendency to lay almost exclusive emphasis on the role of the mother: the bias needs correcting.[101]

Whilst this assessment broadens the blame for the seeds of psychopathology in early life, it is no less gendered in itself. The paternal role is linked to wider society, an example or template. The mother remains the provider of love. Batchelor's and Napier's attempted-suicide pathology is still a pathology produced through a model of the home that is explicitly normative: 'We have used the term "broken home" as it is commonly used, to imply that the children in that home have been deprived of a normal life with their parents'.[102]

Childhood situations are deemed the most pivotal, and yet most difficult to access:

> To assess emotional climates with regard to their normality or abnormality, to express in simple objective or qualitative terms such things as parental quarrelling or rejection and cruelty in parental attitudes, to eliminate the bias of not only the patient but also of his observer ... to give more than a very impressionistic opinion of a certain home in the retrospect of (usually) many years, is, of course, a most formidable task.[103]

Batchelor and Napier admit that 'evidence has almost certainly been missed' and that their tables of data cannot 'give a full statement of the complexity of the situations which were revealed' even though 'in every case relatives were also questioned'.[104] The questioning of relatives by the PSW is explicitly intended to uncover the past social

constellation, but Batchelor and Napier admit that 'we have only the roughest clues as yet about how this factor [broken homes] operates'.[105]

Collaboration between psychiatrist and PSW provides the former with authoritative access to a realm of social information unavailable to Hopkins's observation ward in the late 1930s. But rather than simply document how broken homes are unearthed and emphasised through PSW enquiry, it is possible to see how visions of the social setting might be organised through these conceptual assumptions. This is most visible around statistics, as a considerable amount of effort is required to produce meaning when combining a set of numbers and a social constellation. At first, it appears that numbers are the problem in themselves. Batchelor and Napier state that the statistical tables in these articles cannot give 'a full statement of the complexity of the situations which were revealed ... no indication has been given of how some of these unfortunates were driven pathetically from pillar to post for their shelter'.[106] Statistics seem inadequate to display the social constellation. This is reiterated in 'Alcoholism and Attempted Suicide': 'These bare figures give some measure of the great frequency, but can give no picture of the quality, of disturbances in the childhood home-life of individuals'.[107] Numerical knowledge seems unsuitable for expressing childhood emotional deprivation.

Although psychosocial attempted suicide seems unsuited to statistical expression, these articles also show how Bowlby's ideas organise meaning out of complexity, despite the limitations of statistics. Whilst it is claimed that '[f]igures can, of course, indicate [things] only very crudely', they have meaning, nevertheless: They are, [however], sufficiently striking: parental alcoholism occurred in 38.1% of the cases, loss of the father in 33.3%, loss of the mother in 21.4%'.[108] The striking quality is sufficient to trump any crudeness. In another example, the concession that '[b]are, numerical data can give, of course, only a crude picture of family situations' appears with the qualifier that 'these data are at least factual'.[109] Even more explicitly, in 'Broken Homes', commitment to complexity is significantly organised by overarching ideas:

> To discuss in isolation the importance of broken homes in the aetiology of suicidal attempts, is to incur all the risks attendant on focussing attention upon a single aspect of a highly complicated situation. On the other hand, the figures presented in the tables above are so striking in many respects that to abstract this aspect of the problem seems justifiable.[110]

A Bowlbian conception of a broken home organises these numbers into meaning. Historian Joan Scott argues that statistics are involved in 'organizing perceptions of "experience"',[111] but here, Bowlby's conception of psychological development organises these statistics into significance: 'There seems, therefore, to be a particularly close relationship, which is psychologically understandable, between broken homes and suicidal trends'.[112] This is explicit evidence of what might be fore-grounded under certain conceptual schemes, through what appears to be psychologically understandable: a past social environment anchored around a pathological broken home.

Information about social environments in the past, understood through ideas of pathological broken homes cannot be well-expressed in numerical form. The information is deemed too complex, too rich, too varied, even too emotionally charged (children 'driven pathetically from pillar to post'), to be expressed by numbers. However, these numbers still have meaning, because the same ideas that make these childhoods relevant organise the numbers so that they are 'psychologically understandable'. I am not arguing that Bowlby alone connects psychopathology to disruptions of nuclear, normative family units (they also resonate with Adolf Meyer's life-events, for example). However, the connections between PSWs, child guidance, explicit reference to Bowlby and visions of childhood emotional environments show the importance of PSW input to this reading of attempted suicide.

'Broken homes': aetiology and intent in the past

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

The historical nature of the Bowlbian broken home complicates intent through notions of development. The significance of a broken home for healthy development is clearly described in Batchelor's 'Repeated Suicidal Attempts' (1954) – leading to a 'low frustration threshold' from a lack of socialisation and minimal training in tolerating setbacks.[113] Ideas of development and adaptation help to undergird a socially inflected 'attempted suicide'.

Batchelor makes this claim: 'We may suppose that a broken home tends to render the individual less adaptable and, therefore, more vulnerable to the stresses of adult life and in particular ... personal relationships'.[114] Thus any present interpersonal social context is mediated by a lack of adaptability caused by a broken home.

In Bowlby's terms, these failures of adaptation are underpinned (at least in *Maternal Care and Mental Health*) by analogy with embryological development. He argues that 'pathological changes in the embryo's environment may cause faults of growth and development ... This is a finding of great importance, which, as will be seen, is exactly paralleled in psychology'. A second embryological analogy is deployed, linking the severity of developmental faults to the maturity of the tissue damaged; the earlier the damage, the more severe the consequences. For Bowlby, this constitutes a 'biological principle' that can connect 'far-reaching effects to certain emotional experiences occurring in the earliest phases of mental functioning'. He is almost protesting too much when he rounds off the argument by saying that these ideas, 'so far from being inherently improbable, are strictly in accord with biological principle'.[115] Bowlby's encounter with ethological methods of sense-making and the languages of stress and coping (what Rose calls 'an heretical amalgam of psychoanalysis and ethology'[116]) proceeds throughout the 1950s. The ethological influences are only published in a coherent theoretical position in 1958.[117] It is not just the changes in Bowlby's account of this link between childhood experiences and adult attempted suicide that complicate intent. Any such temporal link disrupts simplistic notions of intention, as these pivotal experiences are temporally distant or unconscious (or both).

What is important here is that the social setting's importance is rooted in the childhood history of the attempted suicide patient; this history impacts upon the present through a disruption of the individual's ability to adapt and cope with present situations. Bowlby describes this as 'unseen psychic scars ... which may be reactivated and give rise to neurosis in later life'.[118] The social constellation most relevant to this conception of attempted suicide does not lie in the environment that immediately precipitates the attempt, but in the deferred pathological effects of a childhood broken home, effects which stunt the emotional development of the individual. The social setting figures as past impediment, not present precipitant.

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

Stengel and Cook: PSWs and a present-centred appeal

The work of Erwin Stengel and Nancy Cook at London observation wards is central to the phenomenon of socially embedded attempted suicide. The extent to which this work resonates with developments in general hospital psychiatry is less well-known. Richard Mayou shows how Stengel's and Cook's reading of attempted suicide and the association of psychiatry with general hospitals are intimately connected:

> [A]ttempted suicide has accounted for a substantial proportion of the cases referred in descriptions of [psychiatric] consultation services published since 1960. However, until the 1950s, hospital cases of attempted suicide were rarely seen by psychiatrists, and indeed, the clinical characteristics were not defined until the publication of a monograph by Stengel & Cook (1958).[119]

Attempted suicide and psychiatric expertise in general hospitals are inextricably linked, and this object is seen to emerge with Stengel and Cook. W.H. Trethowan's 1979 recollections bear out this transformation from somatic injury to psychological cry for help. He does not recall a single lecture on suicide when he was a medical student at Cambridge University and then Guy's in the late thirties and forties,[120] but does remember that

> in the unsuccessful attempts – whether these ultimately proved fatal or not – it was the more immediate after effects which excited the greatest clinical interest – such as the cicatrisation [scarring or distortion of bodily tissue] which might follow corrosive poisoning, or dealing with the partial exsanguination [blood loss] and various surgical complications in those who had made more-or-less determined attempts to stab themselves or cut their throats.[121]

Trethowan attributes to Stengel's work (in the 1950s) the redefinition of such unsuccessful suicide attempts. Indeed, he claims that from his perspective in 1979 'attempts at suicide have become such a wellestablished form of communication between a person in distress and his environment that a satisfactory substitute is almost impossible to find'.[122] This shows how far the idea of communication has become entrenched – indeed, the shift from somatic to communicative concerns is explicitly linked to Stengel. The intellectual and practical labour underpinning this work is considered next.

Stengel studies medicine in Vienna in the 1920s, flees the Nazis in the late 1930s and enters Britain with the help of Ernest Jones and the British Psychoanalytical Society. He becomes one of the most successful and influential psychiatrists of the group escaping Central Europe in the 1930s (including Anna Freud, Willy Mayer-Gross and Joshua Bierer). He becomes a research fellow at the Crichton Royal Hospital in Edinburgh in 1942, director of research at the Graylingwell Hospital in Chichester in 1947, and reader in psychiatry at the Institute of Psychiatry (IoP) in 1949, as well as a consultant at the Maudsley. He takes the chair of psychiatry at Sheffield in 1957 and serves as the last president of the Medico-Psychological Association. Whilst his training (in 1920s Vienna) is unsurprisingly influenced by the psychoanalytical ideas, according to Aubrey Lewis's memorable phrase, Stengel is 'only singed by psychoanalysis'.[123]

Stengel publishes papers on 'Fugue States' (1941) and 'Pathological Wandering' (1943).[124] In 1950 he publishes a literature review on suicide, labelling fugue states 'symbolic suicidal acts'.[125] Thus his work begins to approach complex issues of suicide and intent. His first major clinical investigation of attempted suicide is based upon general hospital patients referred to mental observation wards in London. The cases that provide the basis for *Attempted Suicide* are split into five groups. Groups I and II are created using medical records from St Francis observation ward (1946–7) and the Maudsley (1949–50), respectively. These records are used to identify cases and to attempt follow-up (the patients are interviewed by Kreeger, in his role as psychiatric research assistant, the relatives by Cook, the PSW). Group III consists of patients interviewed at St Francis by Stengel throughout 1953, soon after their attempt. Group IV reverts to the study of records, this time from a North London observation ward (St Pancras) for the same year (1953); these are compared with St Francis. Group V is accessed through an arrangement with Dulwich General Hospital, where every patient admitted there after a suicide attempt between 1951 and 1953 is psychiatrically assessed. (There is also 'Group S,' based on coroners' suicide statistics, which is kept separate and used as a basis for comparison and differentiation.)

St Francis's observation ward is the most important site, so a brief history is required. After the 1929 Local Government Act, St Francis becomes closely associated with Dulwich General Hospital; from 1948 they are under the same Hospital Management Committee (Camberwell).[126] Stengel's research project is funded by the Maudsley and Bethlem board of governors, and there are many connections between St Francis and the Maudsley, enabling access to high-intensity psychological scrutiny on a general hospital ward: Edward Mapother's, then Aubrey Lewis's, regular visits; W.H. Trethowan, who 'learned a lot' as a locum there when training at the Maudsley; Michael Shepherd recalls the 'old observation ward at St Francis Hospital with which I was associated for a long time'; Felix Post conducts studies there.[127] These arrangements and connections provide consistent psychological scrutiny from a world-leading centre of psychiatric research to a ward of a general hospital.

For Stengel, Cook and Kreeger, '[t]he self injury in most attempted suicides, however genuine, is insufficient to bring about death and the attempts are made in a setting which makes the intervention of others possible, probable, or even inevitable'. This repeated emphasis on the setting or environment is absolutely vital to the whole project. They argue for ambiguity in any intent, stating that '[w]e regard the *appeal character* of the suicidal attempt, which is usually unconscious, as one of its essential features'. They argue that 'if we think in terms of a social field we may say that those who attempt suicide show a tendency to remain within this field. In most attempted suicides we can discover an appeal to other human beings'.[128] This is a significant shift from Batchelor and Napier: a present-centred appeal underpinned by unconscious intent rather than a frustration reaction linked to childhood maladjustment. As the attempt is cast as a communication with the attempter's social circle, great pains are taken to document the circumstances of the attempt. Attempted suicide is rooted in the mixed therapeutics of observation wards, allied to PSW practice. In both Edinburgh and London, the different social constellations derive from and require intense PSW-enabled scrutiny.

Referral, therapeutic mixing and rising psychiatric scrutiny in 1950s observation wards

Whereas at Edinburgh's Ward 3 most patients are conveyed directly to that ward, a substantial proportion of attempted suicides in this study are referred to the London observation wards from general hospitals. In Group I (St Francis

records, 1946–7), over half of the attempted suicides reach the observation ward, having been transferred from one of 16 local hospitals. In Group III (St Francis's patients interviewed by Stengel in 1953), over two thirds of attempted suicide patients are referred from other hospitals, rising to over 70% in the final observation ward group (Group IV from St Pancras). Combining all three observation ward groups, just over two thirds of attempted suicide admissions are transfers from other hospitals. This dwarfs the other methods of registering (by police and duly authorised officer). Stengel notes that the majority of attempted suicides are referred from other hospitals, something which is not the case for other kinds of observation-ward patient.[129] It is clear that consistent movement from a place of general medical therapeutics to a separate space with potential psychiatric scrutiny underpins the research. Whilst Batchelor and Napier rely on transformations enabled by mixed therapeutics, Stengel and Cook rely on a different cross-over: established, well-used channels of referral. Hospital–observation ward referral is also crucial because there exists no central collection agency recording attempted suicide. Through referral, records of these attempts – which would have otherwise remained disparate – can form the basis of a research object.

In *Mental Illness in London* (1959) Vera Norris argues that the Board of Control's negativity towards observation units during the 1930s stems from the fact that many of the units are at that point situated in unsuitable public assistance hospitals, staffed by people without psychiatric experience.[130] Donal Early, surveying 15 years' change in observationward use in Bristol, notes that it was only the inauguration of the NHS in 1948 that prompted the provision of psychiatric cover to the ward.[131] Psychiatric scrutiny is increasingly provided for observation wards from then on, but in most cases it is judged to be at a low level. In 1954 John Marshall describes co-operation between psychiatry and general medicine as 'sadly lacking', and J.B.S. Lewis (superintendent of St Bernard's (Mental) Hospital, in Southall, Middlesex) labels observation wards as 'the weakest link in the administrative set-up for the mentally sick' because they are often run by clinicians without significant psychiatric expertise.[132] Despite this, during the 1950s there is a slow increase in psychiatric scrutiny on these wards. This increase should not be overstated, as even in the later 1950s, Norris observes that 'the primary function of these units is reception and diagnosis' and it is argued by others in 1961 that St Francis's ward 'preserves its traditional role of diagnosis and disposal'.[133]

However, *Attempted Suicide* is not solely based upon observation wards. The 76 patients in Group V are seen by a different arrangement at Dulwich General Hospital. General hospital psychiatry outside of observation wards is hugely uneven in this period. After leaving the Maudsley in the late 1940s, psychiatrist Max Hamilton joins University College Hospital (UCH), where: 'At first, they didn't know what to do with me. After a while, I managed to establish a job in liaison psychiatry ... word got around that somebody was available'.[134]

Between 1951 and 1953 a special procedure is put into place at Dulwich to enable psychiatric scrutiny: 'It was arranged that during the period under survey every admission for attempted suicide should be seen by the psychiatrist in the team [Stengel]'. But, '[i]t is possible that sometimes he was not consulted ... This applies particularly to patients admitted to the surgical department'.[135] Not only do Stengel and colleagues have to arrange to see the attempted-suicide patients, anxiety remains that patients might escape psychiatric scrutiny. Something similar is noted during a discussion of a five-year study of psychiatric referrals at Guy's Hospital in 1962. It is claimed that 'there is nothing new or unexpected in the observation that physicians call for psychiatric consultation more often than surgeons'. This is attributed to physicians' greater interest in psychological factors and surgeons' greater tolerance of mental symptoms.[136] Thus within a hospital – between the specialisms considered inside the label 'general medicine' – different regimes of referral and different professional identities complicate the constitution of any clinical object.

This state of affairs potentially blocks psychiatric attention from some of the more severely injured patients – for example, those who require surgery rather than first aid. Put another way, less gravely injured patients have more chance of obtaining psychiatric attention when brought to a general hospital under this arrangement. Equally, recalling Lowden's observations earlier in the chapter, such patients might be sent home from A&E. The potential for more seriously injured patients to escape Stengel's scrutiny has consequences for his ideas about demonstrative or appeal-based attempted suicide. Referral is a vital practice that bridges therapeutic regimes, but not without complexities and constraints.

Psychiatric resources, intensities of scrutiny and PSWs

The transformations that underpin Stengel's production of socially embedded attempted suicide are broached in the discussions of Hopkins's and Batchelor's and Napier's studies: principally that attempted suicide needs significantly mixed therapeutics and much intellectual and practical work for the transformation from a physical injury to a psychosocial communication. In Stengel's work, the present-centred social constellation around the attempt is

indivisible from the intent presumed behind it. Intent to appeal cannot exist without some idea of a recipient. This contrasts with Batchelor's and Napier's analysis, where a broken home in the past impacts upon present abilities to tolerate frustration. A frustration reaction does not require the presence of recipients or observers, but remains rooted in a past, pathological environment.

Various practices, including follow-up and on-ward interviews (as opposed to simply the use of ward records), are required in order for Stengel and colleagues to make the observation-ward material yield up the communicative articulation of attempted suicide. There are three distinct sets of scrutinising practices: observation-ward records only, observation-ward records and PSW follow-up, and interviews with a psychiatrist on the observation ward. Observation-ward records alone constitute a low form of scrutiny. In the St Pancras observation ward, patients in 1953 (Group IV) are not interviewed. Early in the text it is claimed that the intent behind the action will form a key part of the discussion of Groups III and IV. However, this does not materialise for the St Pancras sample: 'Dangerousness and intent could not be assessed' because the patients are not interviewed by the researchers. For the same reason 'the social constellation at the time of the act could not be established'.[137] (The chapter on St Pancras does not fill three pages.)

Using observation-ward records and Cook's PSW follow-up allows a little more of the social setting to be fabricated around the attempt. In Group I, as well as sifting through ward records, the patients, their relatives, friends, and even employers are interviewed, subject to patient consent. The patients are mostly interviewed by Kreeger and the relatives by Cook. The interview schedules are reproduced in the text; they emphasise questions on matters presumably not found consistently in hospital records and case notes. For example, items on the psychiatrist's schedule for patients include: '[m]arked parental discord or other abnormal environmental stresses or relationships in childhood'.[138] Such questioning performs clear intellectual work, bringing patient history into a relationship with the suicidal attempt and opening up similarities with Batchelor's and Napier's work. However, the focus of the questioning is an exceptionally meticulous attempt to chart the present social environment through repercussions, a clear indication of their importance, and what is needed to achieve its prominence:

> Changes in patient's human relationships and environment since attempt. The patient's views on the rôle of the attempt in bringing about changes in (a) social adjustment, (b) work and financial circumstances, (c) emotional adjustment, (d) sexual and marital adjustment – change in status, further children, etc., (e) change in mode of life of members of his family or friends.[139]

The PSW's schedule (for relatives) contains clear emphasis on the patient's relationships with other family members. The very existence of a schedule explicitly for relatives constitutes a research practice designed to produce an idea of interpersonal relationships related to an attempt at suicide. Most of these informants are seen 'in their own homes, as visits were regarded as essential for full information'.[140] Thus, the research object is produced from more intense scrutiny than the normal records can provide. This is acknowledged as vastly time-consuming in 1952 (in the write-up of the preliminary study, which features as Group I in the book), to the extent that Stengel is not surprised that the resources for this kind of study have not been previously available:

> Only a small proportion of patients were in a mental hospital at the time of the follow-up. The rest had to be traced and their co-operation and that of their relatives had to be won. They proved a very elusive group and we came to understand why such a follow-up had never been carried out before in this country. I wish to pay tribute to my co-workers who overcame difficulties which often appeared insurmountable.[141]

That these patients have not been admitted to a mental hospital is part of the reason they are considered so difficult to trace. As models of psychiatric provision move away from mental hospitals, the techniques used to gather social, biographical and follow-up information around mental illness must change. It becomes clearer why Frederick Hopkins cannot produce such an interpersonal object in the late 1930s.

The 'Results of the follow-up' section contains substantial examples illustrating the social effects of the suicidal attempt. These include subsections such as 'Removal from the scene of conflict' and 'Changes in human relations and in modes of life'.[142] The first case study under the latter heading reads thus:

> Mrs. F.I., born 1910, was unhappily married ... They separated in 1944 ... Soon after she learnt of her impending divorce, her lover told her that he did not intend to leave his family ... She became acutely depressed and tried to

> poison herself with aspirin ... . Three months after the suicidal attempt she resumed work. Her lover left his family after all and at the time of the follow-up six years after her suicidal attempt they were living together and both declared that they were thoroughly happy. She thought that her suicidal attempt had 'brought him to his senses'. Her family, who had been against this relationship had become reconciled ... The suicidal attempt here contributed to the solution of a conflict.[143]

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

The most intense scrutiny involves Stengel interviewing patients at St Francis in 1953 (Group III). He again claims that a 'number of aspects of attempted suicide cannot be satisfactorily studied months or years after the event. Some [of these aspects] have been investigated in this series, all of whom were interviewed ... shortly after their admission'.[144] Thus the highest level of scrutiny achieved in this study involves a research psychiatrist interviewing patients soon after admission, with the investigation of the social element in attempted suicide as the purpose of the interview (allied with PSW follow-up). For a truly satisfactory clinical object, embedded within a social context, the on-ward interview is necessary. The potential for such a high level of psychiatric scrutiny is simply not available in observation ward of the interwar period.

The reconstruction of intent here is used to downplay the significance of somatic in favour of psychological consequences. Case studies illustrate this and contain frequent references to a social environment that modifies assessments of (physical) seriousness. For example, a woman who had taken a large dose of sleeping tablets and then 'called her sister with whom she was staying and told her what she had done ... Her attempt was graded as *absolutely dangerous, with only slight intent* . Had her sister not been available the attempt would probably have proved fatal'. A woman whose husband had been unfaithful 'took 100 tablets of codein-phenacetin compound when alone at home but knew that her son would come soon and she expected that he would find her alive ... The attempt was graded as *relatively dangerous, with slight intent* '.[145]

In light of all this effort, *Attempted Suicide* 's most quoted passage takes on a different hue:

> There is a *social* element in the pattern of most suicidal attempts. Once we look out for the element we find it without difficulty in most cases ... If we think in terms of a social field we may say that those who attempt suicide show a tendency to remain within this field. In most attempted suicides we can discover an appeal to other human beings.[146]

The idea of looking for the social element, the intellectual move to think in terms of a social field, the discovery of an appeal: all these are dependent upon specific research practices. The social field is produced through them – finding relatives years after an event, sending letters asking for an interview, asking permission to speak to the former patient. It is quite a practical achievement to produce a credible social, interpersonal space around the paper record of an attempted suicide. Observation-ward records are useful, and follow-up is more useful still, but on-site interviews with the senior research psychiatrist are indispensable to a present-centred social constellation in which to position the suicide attempt in observation wards.

Concluding thoughts

Insights about the significance of social groups and social relationships to mental health and disorder are catalysed by the Second World War. Interaction between psychological and general medical scrutiny is strengthened by the inauguration of the NHS and the inclusion of mental health in the comprehensive service. This is the post-war social settlement, the welfare state and social support networks that are later rolled back by the neoliberalism of the 1980s. Attempted suicide emerges with greater regularity in mental observation wards in these socially focused times. These wards exist uneasily between separate therapeutic approaches, and the increased psychological and psychosocial scrutiny in them is of the highest importance for this new reading of attempted suicide. In this chapter it is shown that when crossover occurs – through mixed therapeutics, referral, or both – the scrutiny must be intense. Much of this intensity is provided by the follow-up practices and intellectual frameworks of psychiatric social work and child guidance, informed by a psychosocial focus that emerges energised from the war. It is also institutionalised by the post-war welfare settlement. The political will to intervene in, manage and treat the social setting feeds into and feeds off this psychological object. Whether the social constellation is fabricated around deprivations projected into

childhood, or through a complicated, largely unconscious, appeal to a present social circle, it is highly labour-intensive.

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

Footnotes

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35 Ibid 3

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