11 CREATING 'THE SOCIAL': STRESS, DOMESTICITY AND ATTEMPTED SUICIDE

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'The social' is everywhere. It is difficult to imagine any action or interaction that is outside this pervasive category of modern thought. However, just as the body and the emotions have been found to be historically contingent,[1] 'the social' also has a history. This chapter uncovers a specific production of 'the social' and its consequences, which must be evaluated rather than simply presumed to be inevitable. Despite the sweeping claims made in its name, 'the social' is not monolithic, but is made and remade through various overlapping instances of practical and intellectual labour.

One iteration of this fluid organizing idea is rooted in the encounter between British psychiatry and two world wars, and reinforced by the socialized medicine of the National Health Service (NHS). It gains further prominence through shifts in mental healthcare towards 'care in the community', the emergence of psychiatric epidemiology and the rise of social work, particularly psychiatric social workers (PSWs). These post-1945 arrangements presume and construct a psychosocial realm, an environment connected to mental pathology and well-being through the concepts of 'stress' and 'distress'. These concepts relate diverse social situations to various mental disorders. The aim of this chapter is to historicize this space, variously known as the 'psychosocial', 'social constellation' or 'psychosocial matrix'. It is part of an historically contingent way of seeing the world that informs and underwrites sociology, social work, social psychiatry, psychiatric epidemiology, social history and the social sciences.

This psychosocial space is explored through the emergence of an 'epidemic of attempted suicide as a cry for help' in the 1950s and 1960s in Britain. This involves young people – increasingly female – arriving at Accident and Emergency (A&E) departments having taken an amount of medication deemed excessive, but insufficient to kill them. This action becomes securely cast by psychiatrists and PSWs not as a genuine suicide attempt, but as a communica-

tion with an environment: a spouse, lover, friends or family. This environment is accessed and brought to prominence by PSW practices of spouse interviews, home visits and follow-up. Self-poisoning becomes a female pathology, corresponding to a feminine domestic environment.

Rates charting this phenomenon – termed 'attempted suicide', 'self-poisoning' or 'parasuicide' – fall away after the late 1970s. In one sense, this phenomenon captures the psychosocial at its purest: psychopathology as social action. An act securely associated with mental pathology is performed as a communication with a social circle. Ideas of communication and the social environment are not simply mutually reinforcing, they emerge as part of the same idea: the social environment cannot exist without meaningful information passing between humans, just as communication requires more than one self-contained individual. Communicative action, and the increasing stability of the 'cry for help' as a category, feeds into the self-evidence of a psychologically significant, interpersonal, psychosocial space.

Concepts of 'stress' and 'distress', which are interrelated but not interchangeable terms, are crucial here. Today, 'distress' is more often used in a way that implies a raw emotional state, on which human definitions or interpretations work, shaping it into a form of pathology or disorder through diagnosis. Ian Hacking's work on multiple personality disorder uses distress in this basic sense, arguing that this category 'provided a new way to be an unhappy person … it has become, to use one popular phrasing, a culturally sanctioned way of expressing distress'.[2] In *The Myth of the Chemical Cure*, Joanna Moncrieff similarly decries the lack of consideration given to the impact that psychoactive drugs have 'on someone experiencing emotional distress'.[3] Emotional distress is here an attempt to step back from using more loaded categories such as 'mental illness'.[4]

By contrast, stress is more often used to express a connection between an environment and a mental or physical state; that is a response to environmental stimuli. In the mid-twentieth century, influential stress theorist Hans Selye redefined the word stress as '"the nonspecific response of the body to any demand upon it" [which] was so persuasive that it persisted and remains widely used today'.[5] Thus stress is neither normal nor pathological. However, as with many conceptual innovations, these categories are used rather loosely. Richard Lazarus, author of the influential *Psychological Stress and the Coping Process* (1966), and Susan Folkman quote a prescient passage from 1964 which argues that 'when the word stress came into vogue, each investigator, who had been working with a concept he felt was closely related, substituted the word stress … and continued in his same line of investigation'.[6] However, in broad terms, stress signifies the effect of environmental stimuli on an organism, whilst distress attempts to capture an unstructured mental state or emotional raw material.

Stress has been variably cast as an endocrine reaction, disturbed physiological balance[7] or the source of mental problems in exogenous depression (caused

by the stress of life events), and has been incorporated into psychological rating scales.[8] This is sometimes claimed to derive from 'the chrysalis of psychobiology generated by Adolf Meyer [1866–1950] through his invention and use of the "life chart".[9] Jackson cites the influential works of Harold Wolff, Daniel Funkenstein, Roy Grinker and John Spiegel as evidence that it was this psychosocial approach 'rather than Selye's experimental physiology that came to dominate clinical and epidemiological accounts of stress'.[10] The most influential twentieth-century articulation of stress is found in post-traumatic stress disorder (PTSD), the genesis of which Allan Young has meticulously charted through Veterans' Administration hospitals in the aftermath of the American war in Vietnam.[11]

Because stress and distress are neither normal nor pathological, they enable the boundary between mental health and illness to become porous. Every human experience in a psychosocial realm has the potential to provoke pathology. This chapter asks four interrelated questions. First, what relationships exist between the psychosocial, stress and attempted suicide as a cry for help? Second, how do stress and distress help to produce the psychosocial as a realm for intervention, surveillance and management? Third, what are some of the specific qualities of this psychosocial environment, in terms of gender-specificity and a particular vision of pathological domesticity? Finally, what roles do 'the social' and 'social stress' play in the diagnostic expansionism of psychiatry, through the mobile boundary between mental health and pathology that they enable?

Psychiatric Epidemiology and 'The Social'

Over thirty years ago, David Armstrong theorized a shift from what he called 'panoptic' to 'dispensary' medicine in the early twentieth century:

> the dispensary radiated out into the community. Illness was sought, identified and monitored by various techniques and agencies in the community ... The new gaze, however, identified disease in the spaces between people, in the interstices of relationships, in the social body itself.[12]

The concern of this new gaze with the social body and the relationships between people is charted through a number of medical registers, including psychiatry, paediatrics, geriatrics and general practice. He argues that at 'the beginning of the twentieth century the "social" was born as an autonomous realm',[13] referencing Jacques Donzelot's French-focused *The Policing of Families* (1979).[14]

It is important not to overstate the novelty of this 'social' in the twentieth century. In Armstrong's analysis, moves towards community care in psychiatry are reduced to expressions of power relations. He claims that from 1948, comprehensive healthcare in Britain and 'the contemporary invention and importance placed on community care are simply manifestations of a new diagram of power',

arguing that the 'community was the term deployed to describe that truly social space that had emerged in the calculated gap between bodies'.[15] Consequently the 'social gaze' appears almost totally novel, the result of a radical rupture. However, it has been argued that this social gaze is not new at all. Charles Webster has suggested that the seventeenth-century 'dominance of Baconian natural history' undercuts the claim for the 'Dispensary as an invention of a later age'.[16] Diverse connections can be made and many genealogies traced. Trevor Pearce follows ideas of organism-environment interaction back to the nineteenth-century philosopher Herbert Spencer,[17] and Mary Poovey traces notions of the social body to reformers such as Edwin Chadwick.[18] The extent to which the novelty of the psychosocial is undermined by apparent precursors remains open to question.

However, it can be stated confidently that *something* is new about the links between mental disorder and environment after 1945. The encounter of British psychiatry (especially workers at the Tavistock Institute) with the practicalities and casualties of the Second World War generates many interpersonally-focused psychotherapeutic practices, including Maxwell Jones's work on therapeutic communities,[19] the Northfield experiments of Wilfred Bion, John Rickman, S. H. Foulkes, Tom Main and others,[20] and Adam Curle and Eric Trist's notion of transitional communities resettling prisoners of war.[21] All of these focus upon interpersonal relationships and the importance of communities to mental health and disorder.

These endeavours presume or imply a relationship between environmental conditions and mental states, generating unsettling conceptual gaps. In this way, they can be said to be significantly novel. This is well-illustrated by the rise of psychiatric epidemiology, a set of techniques designed to survey mental disorder in the community and playing a central role in the construction of the psychosocial. The essence of epidemiology is the ability to relate 'findings in the "cases" ... to the defined population in which those cases arose'.[22] Thus, there must exist a credible conceptual apparatus for this relationship between cases and population (for example, the germ theory of disease). The novelty of *psychiatric* epidemiology is clear in light of 'traditional' epidemiological concerns. Up until the Second World War, this approach makes most sense in the quest to control and prevent infectious diseases such as typhoid, cholera and influenza. However, Joseph Goldberger's 'impeccable studies of pellagra', at the turn of the twentieth century in the American South, show that the diseases do not have to be infectious; pellagra is found to be associated with dietary deficiencies.[23]

After 1945, epidemiological methods are increasingly applied in psychiatry, advancing in step with the shift towards community care. Mark Parascandola argues that 'by the 1950s epidemiologic methods and thinking had expanded beyond the mere study of epidemics'.[24] The concept of the 'epidemiology of mental disorders' begins to make sense as a way to describe the distribution and incidence of mental problems within a defined area. However, without an agreed or stable

model for the relationship between environment and mental disorder, this proves to be 'a difficult transition that still troubles epidemiology'.[25] This is exemplified by the reaction of a professor of bacteriology in 1952, who is furious at:

> an undoubted debauchery of a precise and essential word, 'epidemiology' which is being inflated by writers on social medicine and similar subjects to include the study of the frequency or incidence of diseases whether epidemic or not ... to speak of the epidemiology of coronary thrombosis, or of hare lip, or diabetes, or of any non-epidemic disease, is a debasement of the currency of thought. It is of no use saying that the word is being used in its wider sense. It has no wider sense.[26]

Social medicine is singled out for criticism, highlighting the presence of 'the social' at the core of this new epidemiology. Michael Shepherd – the first ever Professor of Epidemiological Psychiatry[27] – quotes and contests the above passage, citing J. C. F. Hecker's *The Epidemics of the Middle Ages* (1859), which deals with an epidemic of 'disordered behaviour, the Dancing Mania [and] makes no distinction between epidemics of infectious disease and those of morbid behaviour'.[28] Richard de Alarcón recycles Jerry Morris's 1957 observation that there are 'many interesting analogies between the dynamics of infectious disease and that of mental illness: from the dancing mania of the Middle Ages to epidemic benzedrine addiction'.[29] However, G. M. Carstairs, head of a research unit on the 'Epidemiology of Mental Disorders', is uneasy about the meaning of the word in 1959, noting that 'I find that this term "Epidemiology" is in the process of acquiring a new, specialized meaning which is at a variance with its generally accepted one: the study of epidemics. As a result I find that even with medical men the term "epidemiology of mental disorders" usually requires some explanation'.[30] Morris's mention of 'interesting analogies' sidesteps conceptual issues, specifically the lack of a single agreed model to relate mental disorder to groups of human beings, rather than individuals. This field is new and contentious and people are cautious and uncertain about what it might mean and how much conceptual sense it makes. Concepts of the psychosocial have not always been self-evident.

Psychiatric epidemiology emerges with the shift towards community care in mental health, both implying and relying on a concept of 'the psychosocial'. Mental disorder is embedded in populations by stress, via social relationships. George Rosen concludes in 1959 that from 'the 18th century to the present there has existed the concept that social stress is in some way related to the causation of mental illness'.[31] However, Rhodri Hayward argues that while such easy associations between personal adversity and physical distress seem long lasting, the component parts of these connections have repeatedly been reconstituted around different goals, using different investigative techniques.[32] The relationship between investigative techniques and models of distress is crucial. Jackson notes 'the capacity for the language

of stress to clearly articulate the relationship between organisms and their environment … in debates about the social and cultural determinants of mental illness'.[33]

Thus stress and distress are centrally implicated in the psychosocial. Psychiatric epidemiology and social psychiatry begin to make sense in the twentieth century through these broad terms which are neither inherently normal nor pathological. They are instead the fabric of social psychiatry, enabling a porous boundary between mental health and illness. Stress performs significant conceptual, sense-making work for psychiatric epidemiology, the bedrock investigative technique of social psychiatry, associating mental disorder with the environment. Thus by the early 1950s, 'the psychiatrist … is incessantly forced to consider the social relations of his patient'.[34] This is the shift with which Armstrong is concerned, describing 'a body constituted by its social relationships and relative mental functioning'.[35] The link between stress and this idea of 'the social' is made clear: within psychiatry, 'sociology has provided a rich and diverse contribution to the extension of the medical gaze … theoretically it, together with psychology, has helped to define basic concepts, such as stress and coping … sociology has reinforced the shift of the psychiatric gaze'.[36] Hayward argues that 'the sheer number of concepts deployed … and the broad variety of narratives that these make possible have attracted widespread critical comment'.[37] This broad variety is precisely the point, enabling stress to bear the conceptual load of bridging environment and mental disorder.

Like 'the social', attempted suicide as a cry for help is often presumed to have existed throughout history.[38] However, an epidemic in Britain between the 1950s and the 1970s has its roots in inter-war mental observation wards, attached to general hospitals.[39] It is publicized by Erwin Stengel, during the 1950s in London, and then by Neil Kessel, in Edinburgh during the 1960s, where it is renamed 'self-poisoning' in order to emphasize that it is not *suicide* that is being attempted, but *communication*. Norman Kreitman arrives at Edinburgh in the mid-1960s, and in 1969 proposes the neologism 'parasuicide'.

The relevance of this epidemic of attempted suicide to the psychosocial is made clear by Stengel and Nancy Cook's foundational monograph, *Attempted Suicide: Its Social Significance and Effects* (1958). Not only does the subtitle bring *social* significance explicitly to the fore, but the text's most-quoted passage leaves no doubt about its centrality:

> 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.[40]

Stress and distress are crucial in Kessel's work. He is not the first to use these terms around this phenomenon, but he is the first to unify it under such a concept.[41] Dis-

tress is what makes his self-poisoners a cohesive group. He asks whether there is 'a unifying basis to self-poisoning acts? Is there some feature that informs them all?' He answers that it is distress that 'drives people to self-poisoning acts: distress and despair, unhappiness and desperation'.[42] He also links this unifying concept to 'the social', arguing that distress, 'whether it stems from depression or from intolerable social circumstances, is always present at the time of the act', a usage that casts 'distress' as more like 'stress', as emanating from circumstances.[43] Irving Kreeger claims in 1966 that 'suicide is not a circumscribed entity but a method of reacting to stress which cuts across most of the formal diagnostic categories'.[44] He argues that in 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'.[45] Two of Kessel's former colleagues declare in 1972 that they 'firmly endorse Kessel's statement that "*distress drives people to self-poisoning acts*."'[46] Stress, as cause and connection, and distress, as both connection and basic category, are explicitly emphasized at the core of the behaviour.

This unifying distress enables the porous boundary of psychopathology that emerges in community mental health, because it straddles both normal and pathological reactions to environments. Indeed, Kessel's rooting of self-poisoning in distress is explicitly part of this complicated relationship between abnormal action and psychiatric pathology: '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'. The troublesome borderline is made possible by a concept that passes through it. The position of distress as negotiating the uncertain boundary of psychopathology is clear: it is distress that 'drives people to self-poisoning acts, and distress is not the exclusive province of the mentally ill'.[47]

A focus on communication is also a basic part of 'the social'. A distress-based, psychosocial approach casts certain 'self-inflicted injuries' as communications with that social environment. In Jurgen Ruesch and Gregory Bateson's *Communication: The Social Matrix of Psychiatry* (1951), Ruesch notes that psychiatrists 'have moved out of the enclosing walls of mental institutions and have found a new field of activity in the general hospitals of the community and in private practice'. This leads to the argument that 'it is necessary to see the individual in the context of his social situation'.[48] He further claims that it is 'the task of psychiatry to help those who have failed to experience successful communication' and that psychopathology is 'defined in terms of disturbances of communication'.[49] Ruesch admits that such a formulation might be a little surprising, but that the sceptical reader need only open a textbook of psychiatry to find that terms such as 'illusions', 'delusions', 'dissociation' or 'withdrawal' in fact 'refer specifically to disturbances of communication'.[50]

Conceptualizing psychiatric disorders as essentially communicative shows how ideas of stress and coping feed into communicative action. Not only does

social stress prompt the communication, but the social environment is also where help is sought through communication. Stress is what enables mental illness and environment to be mutually reconstituted and for that environment to take on psychological importance as 'the psychosocial'. In 1992, Raymond Jack surveys the models that have been used to explain self-poisoning. He acknowledges that stress has been seen as key and emphasizes how closely stress comes to stand for the social environment: 'stress is external to individuals and emanates from the social conditions which govern their everyday lives'.[51]

Knowing and Managing 'The Social'

Having shown that stress and distress are foundational to 'the social', which is co-constituted with understandings of attempted suicide as a cry for help, we turn now to the practical ways in which this realm is envisaged and actively constructed by psychiatric and social work professionals, a process principally achieved through home visiting and spouse and family interviews. Social work is vital to self-poisoning because, according to Kessel, it offers therapeutic possibilities across the unstable psychopathological boundary. For him, it 'does not follow that the patient can benefit from treatment only if he has a psychiatric illness. Nearly half of those without such illness were judged to be helpable by further care, a term which embraces social work as well as psychiatric therapy'.[52] Furthermore, Kessel puts psychiatric social workers (PSWs) right at the heart of this phenomenon.

The roots of psychiatric social work lie in mental after-care and the child guidance movement. Vicky Long notes 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'.[53] John Stewart shifts focus, arguing that PSWs emerge 'after 1918 in an organic relationship with child guidance'.[54] Noël K. Hunnybun, Senior PSW in the Children's Department at the Tavistock Institute, agrees, plotting psychiatric social work's development through 'the medium of child guidance',[55] and tracing the profession back through concerns expressed in Cyril Burt's *The Young Delinquent* (1925), which emphasizes 'the importance of studying the child in relation to his family and social background'.[56] These concerns with 'families' and 'social background' are absolutely crucial, both to PSWs and attempted suicide.

In 1929 the London School of Economics establishes the first PSW training course for social science graduates. The Universities of Edinburgh (1944), Manchester (1946) and Liverpool (1954) follow suit,[57] and the government is also concerned to increase the number of social workers. Eileen Younghusband notes in 1951 that the Cope and the Mackintosh Committees are, at that point, considering 'the supply and demand, recruitment and training of almoners, and of psychiatric social workers and other social workers in the mental health ser-

vice'.[58] She also sees 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'.[59] Political intervention is also noted by Richard Titmuss in 1961, when he claims that numerous 'Royal Commissions and committees of enquiry have discovered in recent years the virtues of the normal social environment – or as near "normal" as possible'.[60]

Of critical importance to British child guidance and to psychiatric social work are the explanatory schemes of John Bowlby.[61] His work reconfigures the psychological crux of the parent-child relationship away from the intricate fantasies, envies and anxieties of orthodox psychoanalysis, focusing on what Anthony Storr revealingly labels 'real life'. According to Storr, while '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'.[62] This constitutes a crucial emphasis on the social origins of psychopathology, where 'the social' is elided with 'real life'.

PSWs are an obvious expression of this psychologized turn towards 'the social' as well as key instruments in the development 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'.[63] Younghusband notes the need for a new kind of social work in mental health which calls for 'a social frame of reference, a fuller recognition of the complexity of human motivation and behaviour, and particularly of family and social interaction'.[64] The broad shift, after 1959, towards 'community care' brings social work to renewed prominence. In the foreword to Alistair Munro and Wallace McCulloch's *Psychiatry for Social Workers* (1968), it is claimed that psychiatry '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'.[65]

It is this 'social frame of reference' that becomes increasingly dominant, part of a broad political project. Influential studies from Aubrey Lewis's Social Psychiatry Research Unit focus upon the role of the family in the recovery from conditions such as schizophrenia.[66] Felix Post – who conducts studies around the same time and on the same ward as Stengel[67] – 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'.[68] Nikolas Rose describes this post-war project in terms of 'minimizing social troubles and maximizing social efficiency',[69] 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'.[70] 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'.[71] Eghigian, Killen and Leuenberger describe a 'new wave of state interventionism ... directed at women, children, and families' in the decades after the Second World War.[72] The goal of this intervention, counselling and casework is to produce what Rose calls the 'responsible autonomous family', a nuclear, private, productive unit comprising well-adjusted, physically and psychologically healthy citizens.[73]

PSWs occupy an increasingly prominent place in Kessel's studies of self-poisoning, which dominate his four years in Edinburgh (1961–5). Edinburgh is the first place outside London to offer PSW training courses. Here, the Meyerian influence of D. K. Henderson, Professor of Psychiatry at Edinburgh (1932–54), makes it a conducive place for PSWs to work. They flourish, for whilst lip service was 'paid to Adolf Meyer's more global picture ... only a minority of psychiatrists seemed to take this seriously in practice. These were the best friends of the PSWs, and valued their support in demonstrating the ... tensions and conflicts in the family and social situation'.[74] PSWs are intimately concerned with access to the 'social situation'. It is through home visiting and the taking of social histories that 'the centrality of the home to child guidance and the part therein of the psychiatric social worker' is established.[75] Indeed, sometimes social workers 'sought to visit the home even before a clinic visit'.[76] The social history is the most basic building block for reliable access to 'the social setting', and Stewart notes that psychiatrists 'appreciated such "social history"'.[77] This is central to PSW practice and takes up considerable time.

Kessel works most closely in collaboration with PSWs Elizabeth Lee and J. Wallace McCulloch. It is noted that 'in Edinburgh the Medical Officer of Health was an enthusiastic exponent of home treatment for the mentally ill and had been training his Health Visitors to act as P. S. W.'s'.[78] When mental healthcare becomes increasingly organized around outpatient departments, especially after 1959, the PSW staples of home visiting and social history-taking have even more potential to fabricate a credible social space around any given case of mental disorder.[79] There is thus significant 'socially-focused' expertise upon which Kessel can draw, but it is still not enough. He complains in 1962 that a shortage 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'.[80] However, a footnote acknowledges that 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'.[81]

Kessel is explicit about PSW prominence in 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'.[82] In addition, arrangements are made for the PSW to

interview key informants such as a spouse or relative.[83] Then 'a clinical conference is held at which the patient is seen by the whole team; social and clinical details are put together and the disposal of the patient is arranged'.[84] These are the practices upon which an interpersonal social nexus is built. In Edinburgh, a routine clinical conference with PSWs has emerged by February 1963, when Kessel writes to *The Lancet* advising that in all cases of attempted suicide a friend or family member of the patient should be interviewed, and that multiple times 'we found that we erred before we made this a rule'.[85] PSWs broaden investigations through follow-up home visits, enhancing the credibility of the resulting social spaces. These projections bring out an explicitly normative social setting which is built into the foundations of attempted suicide:

> 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.[86]

This 'social' is explicitly normal, domestic and potentially psychopathogenic.

Kessel's 'distress' is also informed (through PSWs again) by the marriage guidance movement. This reinforces another crucial practice for constructing 'the social': spouse interviews. Post-1945, psychiatric social work transcends its child guidance heritage, moving closer to marriage guidance, a movement founded in the 1920s with historic connections to PSWs.[87] 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.[88] Elizabeth Irvine reveals of PSW training schemes that the 'psychology of family relations was introduced in the late 1950s, largely taught by members of the Family Discussion bureau (later the Institute of Marital Studies), who sometimes narrowed the subject to marital relations alone'.[89]

The increasingly marital focus of PSWs is evident at Edinburgh: 'marital conflict is the chief aetiological factor in many cases; generally the attempt follows swiftly upon an acute domestic quarrel in a chronically disturbed matrimonial situation'. Kessel and Lee 'stress the importance of the breaking home' rather than a Bowlbian 'broken home' caused by parental divorce or absence.[90] In 1964 Noel Timms registers temporal changes in the 'social history': it is 'possible that the purpose and method of taking the social history have changed, since psychiatric social workers now think they are called on not so much for a detailed expression of family history but for an assessment of the present situation'.[91] The environment imagined around 'attempted suicide' shifts from Bowlbian parent-child relations, becoming more recognizably 'social'. Social work practice implies a *present* social space, a web of relationships, of which attempted suicide is a symptom.

Present marital conflict is only a short step from broader communicative, interpersonal concerns, founded upon distress. Kessel argues that 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'.[92] Self-poisoning is imagined as a powerful weapon by being situated in a social, communicative field founded upon distress. The social constellation allows pathology to be projected onto (or articulated through) somebody who has not even been poisoned. McCulloch and Philip put this most clearly in 1972:

> the Edinburgh studies have shown that among married women pathological jealousy in the husband was found in almost a quarter of the cases. Indeed, the persistent sus-picions 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.[93]

This idea of illness emerges at the point where marriage guidance and psychiatry intersect. J. H. Wallis's influential marriage guidance text includes a chapter on 'The Jealous Husband', where a flexible and potentially expansive sense of psychopathol-ogy emerges when considering whether to refer such a husband to a psychiatrist: 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'.[94] The social constellation, allied to marriage guidance-inspired spouse interviews, is cred-ible enough to support the redistribution of pathology away from the presenting action (self-poisoning) onto a social relationship. Again, the boundary of psycho-pathology is radically mobile, buttressed by specific ideas and practices.

Spouse interviews are central to Kessel's social setting, as he 'noted one phe-nomenon 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'.[95] Here, domestic stress is gendered through a fem-inine lack of resilience, or a masculine lack of support.

The social space, painstakingly constructed through interviews, visits and assumptions, fundamentally informs 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'.[96] PSW practices bring in credible information, accessed through an interview with somebody who is *not a patient*, opening up a space where Kessel's clinical impression gains empirical validation or confirmation. This enables him to speak about a social, domestic space through what he observes 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, Kessel argues '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'.[97]

These practices build a 'social' around marriages, spouses and homes. The clinical conferences and Kessel's clinical impression articulate a socially situated self-poisoning through PSWs, even though their input is sometimes overridden. Visions of the home are created in these analyses, co-constituted with the aetiology of self-poisoning through distress. This is a significant part of the wider project inscribing mental health and mental disorder onto the social, interpersonal fabric of everyday life. This pathological domesticity is crucial in stabilizing the attempted suicide during the 1960s.

Kessel differentiates this feminized, domesticated 'psychosocial' from more traditional readings. He asks whether self-poisoning is 'perhaps the female counterpart of delinquency in young men? Such a hypothesis would suggest that women turn their aggression against themselves, while men act against society'.[98] He rejects this, arguing instead that clinical study leads him to explain self-poisoning through the abovementioned 'emotional isolation' and failure to adapt to the 'confines of domesticity'. Through rehearsal and rebuttal of this hypothesis, Kessel moves away from conventionally masculine, sociological concerns such as crime and delinquency. His analysis recalls Elliot Slater and Moya Woodside's observations gathered during home-interviews of the wives of selected soldiers in the late 1940s, where Woodside reports witnessing 'struggles and ambitions eventually adapting themselves to the limitations of a restrictive environment'.[99] This is not new; marriage, domesticity and psychopathology are historically well-connected.[100] This connection is enabled anew and reiterated by the PSW-founded interrogation of domesticity, which has a fundamental effect on the kind of 'social' that is imagined.

This domesticated social space becomes increasingly gendered throughout the 1960s, interacting with other concerns. The self-conscious nature of Kessel's self-poisoning (compared to Stengel's more unconscious-focused framework) feeds into stereotypes of feminine manipulation, exemplified by Kessel's above-quoted comment about bringing back errant boy friends. Self-poisoning – rather than slashing one's own throat, for example – is also seen as a passive (read: feminine) method which interacts with a gendered imbalance in the prescription of barbiturates. As Ali Haggett states, '[s]ince the 1970s, feminist historians have suggested that the lack of opportunities afforded to women and the banality inherent in the domestic role caused symptoms of anxiety and depression in post-war housewives. Correspondingly, they have argued that the primary motive for prescribing psychotropic drugs was to ensure that women "adapted" to their domestic role'.[101] Finally, distress has resonances with supposed feminine emotionality and hysteria, but is also explicitly articulated as part of this feminized domestic role.

Psychiatry, the social setting and women are closely connected during the 1960s. The classic *Psychiatric Illness in General Practice* (1966) goes so far as to say that 'it would be a justifiable exaggeration to say that in the eyes of the general practitioners, psychiatry in general practice consists largely of the social problems of women'.[102] A gender imbalance in attempted suicide as a cry for help does not seem exceptional in the wider context of reading mental illness into interpersonal, domestic relationships. The idea that women are physically, emotionally, psychologically or evolutionarily more suited to domestic, home or family spaces is a durable plank in circular sexist arguments that feminize domesticity *a priori*.

This is not all. PSWs have their own gendered freight to contribute to the domesticated, psychopathological 'social'. John Stewart notes that during the interwar period, 'social work was … a predominantly female occupation',[103] an assessment echoed by Noel Timms in the post-war period.[104] Of course, the presence of those gendered women in any given profession *does not* mean that the work produced will necessarily 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 associations, and Timms is well aware of the belittling of PSWs by psychiatrists. He recalls an article in the *British Medical Journal* in 1950 on 'The Role of the Psychiatric Social Worker' where:

> Dr J. B. S. Lewis appeared to give full recognition to the psychiatric social worker. 'She should', a report of the meeting states, 'of course, work in close conjunction with a psychiatrist; but it must be remembered that she had a skill of her own, and he could learn from her as she from him. Her duties were multifarious. She had to explain to the patient, his relatives, employers, etc. what the hospital or clinic was doing; to take a social history; to follow-up and help discharged patients; to co-operate with other social services; to help in administration and therapeutic work and in research; and, in fact, to carry out many *other chores*'.[105]

This earnest and patronizing picture is assessed with Timms's sardonic comment that the 'fairly high status accorded to the psychiatric social worker is somewhat diminished by the ambivalent comment in (my) italics'.[106] 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.

Through the routine deployment of practical social work arrangements, the establishment of this particular domestic, gendered 'social' around attempted suicide is highly successful. Stress and psychiatric social work are, respectively, the conceptual and practical means through which circumstances and pathological behaviour become connected. Hence, statements that 'marital disharmony causes self-poisoning' are possible when the latter is encountered on a hospital ward. Once this process begins to recur predictably, when social spaces and pathogenic relationships become presumed and thus self-reinforcing, this particular 'social'

can be considered established. To quote Hacking, 'new possibilities for action' can become 'a culturally sanctioned way of expressing distress'.[107] However, as has been argued here, this concept of distress is linked to socially directed or communicative behaviour in such a comprehensive way that there is not much value in using one to explain the other in the case of attempted suicide. Indeed, explaining a psychological epidemic of *anything* during the twentieth century using the language of distress begs more questions than it answers given the way that stress and distress are constituted at the heart of – and are conceptual guarantors for – the new project of psychiatric epidemiology and its psychogenic social space.

Conclusion

Attempted suicide drives and expresses the broad and eclectic turn to 'the social' in mental health; this 'social' still undergirds the controversial justifications for community care. In addition, the psychosocial environment provides the terrain that makes possible the 'psychologisation' or 'psychiatrisation' of society. It seems obvious today that everybody exists in a social environment and is subject to various stresses in some degree. Through stress, everything is potentially psychopathological, every (social) relationship and (social) situation is on a continuum and carries a mental health risk.

Acknowledging the central role of stress and the psychosocial in the relentless diagnostic expansion of psychiatry allows a more precise position to be taken on the ethics and desirability of this expansion. Stress is a vital conceptual plank in various mental health-care arrangements that create an ever-widening psychosocial field of action. This sounds superficially like the 1960s anti-psychiatry that protests that mental illness is a social, rather than biological, phenomenon. The anti-psychiatric position criticizes the psychiatric profession for conflating the two and participating in 'social control'. Thomas Szasz characterizes 'psychiatry as social action' and the psychiatrist as a 'social manipulator of human material [who] punishes, coerces or otherwise influences people'.[108] These arguments are fully embedded in 'the social'. His work also finds a link between distress, characteristically mobilized as a basic category, and 'the social': 'in so far as physicians try to help persons who are in distress – rather than *only* repair bodies that are deranged – they must have some familiarity with man as a social being'.[109] Whilst Szasz uses distress to step back from labelling phenomena as illness, this usage comes with assumptions of its own; Szasz is merely the logical end point for rolling back the unstable boundary of pathology built into this 'social'. 'The social' becomes a self-evident battleground, the prerequisite for these arguments. Thus it is also largely invisible, undergirding both sides, self-evident and beyond comment. Lives are psychologized (some more than others due to their gender identity) by

the seemingly banal fact that the social and the psychopathological are intimately connected in the 'psychosocial', a connection enabled by the concept of stress.

In the twenty-first century, stress is increasingly understood neurochemically, but not to the exclusion of 'social stress'; that concept still functions to bridge the gap between mental state and environment.[110] It still underwrites 'the social' – with its overlapping assumptions, aetiologies and concepts – which remains one of the most basic categories for understanding human action. The aim of critical history is to uncover the premises for our understandings of the world, to defamiliarize that which seems most natural, to make visible that which is most difficult to see. It roots these premises in time, in space, in context; they are therefore up for debate, subject to review, able to be changed. The ethical consequences (involving diagnostic expansionism, surveillance, enduring sexism and individual rights) of understanding and governing the world through this idea of 'the social' take on new pertinence when placed in context. The idea that we should simply manage or contest, 'roll back' or 'advance', the unstable boundary of pathology is no longer the only thinkable binary. This critique brings into view how the boundary becomes constituted as unstable in the first place.

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