Conclusion: The Politics of Self-Harm: Social Setting and Self-Regulation

Almost three decades ago, historian Howard Kushner writes of his unease at increasingly neurological understandings of behaviour such as suicide. He argues that '[o]ne feature of neuropathological approaches, however, seems unaffected by this increasing sophistication: the more scientifically complex these investigations become, the more they tend to ignore the social and historical context in which the behavior that they seek to explain takes place'.[1] In these accounts, neurology displaces social context. In characteristically forthright terms, in 2014 Roger Cooter describes the turn to neurological explanations as 'like becoming the victim of mind parasites' because these explanations foreclose the ability to think critically about the social and cultural context of the explanations themselves: they are presented as universally true and outside of culture or history.[2]

Self-harming emerges as an epidemic in Britain as pathological social communication and is transformed into affective self-regulation. Therefore it can serve as a barometer of broader changes in understandings of human behaviour. Self-harm in the form of self-poisoning is understood as highly social; the self-damage by self-cutting, which displaces it, is understood as predominately internal. It is this internal, emotional quality that enables its easy fit within neurological and neurochemical frames of reference. The career of these behavioural archetypes can tell us much about the dominant ways in which human behaviour is understood: the ways in which behaviour is given meaning according to cultural assumptions that shift in their relative influence and credibility. In this conclusion I seek to do five things. First, I recap in summary form, the book's main arguments and content. Then I want to reflect a little on the book's methodological underpinnings, to show that I do not exempt myself from the kinds of analysis carried out in

the book. This happens in the Conclusion rather than the Introduction because it is easier to reflect in a comprehensible way upon this process when the argument has been laid out. Third, I sketch (very briefly) some of the ways in which self-harm-as-affective-regulation is now within the orbit of neurological explanations. Fourth, I expand upon the political significance of the internal, emotional understandings of self-damaging behaviour. Finally, I reflect upon the implications of this historical account of self-cutting and self-poisoning for human behaviour in general.

Summary of argument

Self-poisoning as pathological communication has a relatively short shelf-life. In 1975, Eliot Slater produces an article describing the state of psychiatry in the 1930s. He observes that '[t]he young in those days did not have today's facilities for drug addiction, for self-inflicted wounds, for attempted suicide as a "cry for help"'.[3] What seemingly starts as a comment on the increased level of drugs circulating in 1970s society strikes a much more profound note by the end. In the 1930s, the 1970s patterns of 'attempted suicide as a cry for help' are simply not available. In the twenty-first century, whilst not invisible, self-poisoning as a cry for help has been eclipsed by deliberate self-harm, based around self-cutting for emotional self-regulation.[4]

As we have seen, between the 1930s and 1970s a number of objects under a variety of names (attempted suicide, pseudocide, self-poisoning, parasuicide) emerge through traffic between the therapeutic approaches of general and psychological medicine. Throughout the middle third of the twentieth century the relationship between psychological and general medicine is reconfigured, and the concepts used to label, treat and analyse patients presenting at hospital with a self-inflicted physical injury are subject to much change. Actions configured around violence and a fear of imminent fatal repetition give way, slowly and unevenly, to actions interpreted as a result of childhood psychological trauma, or attempts to communicate social and domestic stresses. This is not just a change in interpretive strategy, with some form of object constant beneath these different responses: the objects are fundamentally reconstituted in different contexts, by different practices.

The police-watching controversies articulate a concern over 'would-be suicides' due to a financial dispute between the police and voluntary hospitals. The potential for violence and repetition is emphasised as part of a strategy by hospitals to compel police to remain in attendance

whilst the patient is treated. The potential for immediate repetition carries with it the implication that the attempt is aimed at death. A dispute then emerges between workhouse infirmaries and voluntary hospitals that again emphasises violence, but this time in order to place 'attempted suicide' within the remit of workhouse infirmaries, as they are supposedly better equipped to deal with mental patients.

Legislative changes in 1929 and 1930 abolish the Poor Law and promote the informal (non-certified) treatment of mental disorder. As a result, psychological and general medicine come into a closer relationship around (mental) observation wards attached to general hospitals. In many cases these wards are the old workhouse infirmary mental blocks, with workhouse infirmaries turned into local authority hospitals at the abolition of the Poor Law. This closer relationship gives Consulting Psychiatrist Frederick Hopkins consistent access to various 'physically injured' patients brought to his Liverpool observation ward. This arrangement makes visible a broadly coherent group of people whom he deems to have attempted suicide due to various social and constitutional factors, including 'domestic stress'. He is aware of, but equivocal about, an old notion that attempted suicide is principally a manipulative communication.

The engagement with the psychological casualties of the Second World War prompts a number of interpersonal therapeutic experiments. Psychological problems and mental suffering are seen as inseparable from factors in the social environment. As part of this process, therapeutic communities are established at various sites in the United Kingdom by psychiatrists including Tom Main, Maxwell Jones, Wilfred Bion and John Rickman. Social environment and psychopathology become ever more closely entangled.

In 1948 the NHS is inaugurated, with mental health included in the comprehensive service. This removes any disputes about payment for certain classes of patient and effects a closer connection between general and psychological medicine. It is also part of increased collective and social welfare provision, nationalised industry and centralised planning. The remit of the state to manage, fund and direct social life (through social work, child protection, child guidance, welfare requirements and so on) is expanded. As part of this shift towards collective provision, the connection between mental and physical medicine is strengthened. At accident and emergency (A&E) departments for cases of attempted suicide, this link is not sufficient to produce a social constellation around a physical injury conveyed to hospital. The presence of psychological medicine is still too marginal in casualty departments,

where the overwhelming focus is acute somatic medicine. However, in the early 1950s facilities for the treatment of poisoning, psychological scrutiny and psychiatric social work (PSW) expertise all converge at an observation ward in Edinburgh. This results in psychological scrutiny of physically injured patients, but also in the rooting of psychopathology (through the conceptual apparatus of John Bowlby) in childhood emotional deprivation in so-called broken homes. Psychiatrist Ivor Batchelor and PSW Margaret Napier operate in tandem to construct a vision of psychological maladjustment and low stress tolerance in the background of these attempted suicide patients. This is largely achieved through intensive questioning and assiduous follow-up by PSWs. A similar object of concern is publicised around the same time in London observation wards by Erwin Stengel and co-workers (principally PSW Nancy Cook). This attempted suicide is again part of a crossover between mental and general medicine, but more focused upon a present-centred (often unconscious) appeal, in response to social difficulties.

In the late 1950s the final legal impediments to psychological treatment at general hospitals are swept away in the Mental Health Act (1959) as part of a wider effort to eliminate as far as possible the differences between the treatment approaches. Connected to this effort, and using Stengel's research, suicide and attempted suicide are decriminalised in England and Wales in the Suicide Act (1961). Both of these acts remove legal machinery from areas considered psychological in nature. Thus, to ensure that the appropriate kind of care is forthcoming, they are swiftly followed by government guidance to hospitals recommending psychological assessment for all attempted suicide cases seen at accident and emergency departments. This is actively followed up by the Ministry of Health; the variable results recorded demonstrate the difficulty of focusing intensive psychological scrutiny at casualty departments.

Whilst the government passes legislation, the Medical Research Council (MRC) sets up a unit for psychiatric epidemiology that ends up in Edinburgh, at the same ward that produces some of the 1950s studies. With the MRC's backing, Neil Kessel embarks upon a project to study 'attempted suicide', which he renames self-poisoning. Collaborating extensively with PSWs, Kessel roots the causes of self-poisoning firmly in the present, and as a conscious appeal, in an all-encompassing category of distress, centred upon a feminised vision of the home and supposed marital disharmony.

As the government starts to run down the asylum system and promote psychiatric units in general hospitals, a large number of studies, with varying degrees of psychological scrutiny, are able to

effect the transformation from 'physical injury' at casualty to 'socially rooted appeal'. The growing self-evidence of the social constellation (in a society where the state's social responsibilities are much larger than today) remains a product of much intellectual and practical effort. It means that a broadly causative social setting is increasingly presumed around a casualty admission for poisoning. This presumption makes the behavioural category increasingly stable, public and available as an intelligible human response to interpersonal difficulties. This broader self-evidence fuels new terminological offerings, with 'parasuicide' the latest neologism, proposed in 1969.

Alongside (and entangled with) this story runs that of self-cutting from the early 1960s. Self-cutting (especially of the wrists and arms) has long featured as a seeming methodological quirk in self-poisoning and parasuicide studies, presenting at hospitals as approximately 5% of cases of self-damage. In these general hospital-based studies, self-cutting or self-lacerating are not seen as motivated differently to self-poisoning. However, self-cutting also emerges in the context of psychiatric inpatient institutions. Influenced by North American psychoanalytic inpatient literature, a British corpus of studies on self-cutting, self-mutilation or wrist-cutting emerges. This is initially seen as related to the strictures and constraints of the inpatient environment and provokes much interest and concern due to its highly distressing and contagious epidemic nature. However, as the 1960s pass into the 1970s, a sense emerges from these inpatient studies that self-cutting is motivated by internal, emotional psychopathology grounded in a sense of intolerable psychic tension.[5] This sense remains strong in the current literature on self-cutting. As Karen Skegg reports in 2005 in the *Lancet*, this is not a clear-cut disavowal of communication, but instead the relative dominance of internal, emotional and tension-based factors: 'Reported motivations for adult superficial self-mutilation included: to relieve tension, to provide distraction from painful feelings, as self-punishment, to decrease dissociative symptoms, to block upsetting memories, and to communicate distress to others'.[6]

This re-reading of self-cutting is then (from the late 1970s) imported from the inpatient studies into the A&E-based samples. This first seems to be done coherently and explicitly in a study conducted by Keith Hawton in the mid-1970s and published in 1978. This differentiation then begins to make sense of the hospital/A&E presentations during the 1980s. Thus the idea that self-cutting and self-poisoning are differently motivated behaviours begins to gain traction. Self-cutting becomes stabilised as a method of internal affective regulation, whilst self-poisoning is

rendered more ambiguous: it features both as a genuine suicide attempt and socially directed self-damage.

The growing ambiguity of self-poisoning and its eclipse by self-cutting might tentatively be connected to a fracturing of the kind of psychological expertise that first produced it. Between 1977 and 1980 a number of clinical studies are published that question whether assessment by psychiatrists is necessary in every case. A consensus is reached that other professionals such as social workers, nurses or junior doctors – with some training provided by psychiatrists – are equally competent to do this.[7]

In 1981 a working party is set up by the Royal College of Psychiatrists at the invitation of the Department for Health and Social Security (DHSS, successor to the Ministry of Health). The group includes Norman Kreitman, Hugh Gethin Morgan and Irving Kreeger, who are asked to review government guidance on the management of deliberate self-harm. (This term is defined in the report as covering 'patients who injure themselves by poisoning or other means' – so poisoning is predominant here.) One of the outcomes of this working party is that a Hospital Notice is issued in 1984, drawing attention to the report included with it. Specifically, the notice emphasises the recommendation that 'suitable trained medical practitioners, other than psychiatrists, may undertake the psychosocial assessment of patients who deliberately harm themselves, and that referral – in some cases, to professional workers, other than psychiatrists, who have received special training – may be considered appropriate'.[8] Thus, right at the point where self-poisoning treated at hospitals is becoming differentiated from self-cutting, the assessment of the (largely) self-poisoned patients at A&E can be delegated away from psychiatrists.

This fractures the intense psychiatric scrutiny (based around research articles) that has been shown to be so important in stabilising socially directed self-poisoning as a self-evident object of enquiry. So here again are specific practices that are prescribed by the state, and that influence the visibility of a psychological object. As much as the rise of self-cutting might resonate – somewhat perversely – with neo-liberal ideas of self-reliance, and be part of the retreat of the state from social welfare spending (which is further explored below), there are still specific, mundane, administrative practices that correspond to the retreat of self-poisoning from national significance.

It is not coincidental that the texts at the forefront of raising awareness about self-cutting do not normally come from A&E, but instead from psychological clinicians involved in counselling – where the potential for intensively scrutinised case studies is much higher than

in busy hospital casualty departments. In addition, visibility is granted to self-cutting through its inclusion as a symptom of borderline personality disorder in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* in 1980.

Methodological reflection

This story is told through two principal sources of information: articles in medical and psychiatric journals, and government documents at the National Archives, Kew, and at the Lothian Health Services Archive in Edinburgh. In the first category there are also some dissertations – principally McEvedy (1963), Keller (1970) and Waldenberg (1972) – that are not in journals, but still adopt the style, tone and formality of psychiatric research. The sources at the National Archives provide the basis for discussions of the police-watching controversies of the early twentieth century, the machinations around the Suicide Act and Hospital Memorandum (1959–61), some extra information on Kessel's Edinburgh unit (1961–5), and the hospital notice of 1984. The Lothian Health Services Archive principally furnishes extra information about Ward 3 of the Royal Infirmary of Edinburgh.

Although archival sources form a significant proportion of this book's basis, the predominant source base remains scholarly psychiatric research articles. Because these are written with scholarly apparatus (chiefly references), I am able to follow acknowledged trails of thought and influence. I use these to construct a more or less established 'canon' of documents by authors who refer to each others' work. The key names should be familiar – Hopkins, Batchelor and Napier, Stengel and Cook, Kessel, Kreitman. This means that much of the rise (and fall) of self-poisoning is seen through the lens (and constraints) of research output. When this significantly drops off, and self-cutting largely displaces it as the meaning of 'self-harm' or 'self-damage', this does not mean that I am making a strong argument about the numbers of people performing these actions. As I hope is clear, the numbers of people reported in any given study depend largely on the institutional basis for such a study (for example, whether inpatient or outpatient) and on the specific practices used to find and evaluate cases.

This historical method is paired with very tight focus on the subject matter of the articles: unpicking lines of argument, searching for mentions of specific practical arrangements, evaluating the position of various professionals (PSWs, police, etc.). It does not leave very much space for the 'patient experiences' of self-cutting or overdosing. This features in a

small way, when patient testimony is used and deployed by psychiatrists as evidence. This is especially useful when patients confound expectations (as in Watson's 1970 study), or requires significant intellectual work to make it fit (as in Waldenberg, 1972). However, this is principally a study of specific hospital practices, a certain set of psychiatric ideas about the social setting, and how these might resonate with a wider political context: a shift from a welfare-based, socially interventionist consensus to one of individuated, market-oriented competition. Roy Porter champions ideas of the 'patient's voice' as central to the history of medicine, but this is not my principal area of interest.[9] I am far more concerned with how ideas and research practices interact and produce the concepts and shorthand that humans use to understand themselves and others. Basing this book on the experience of the patient would make it a very different project. In addition, Joan Scott writes persuasively:

> When experience is taken as the origin of knowledge, the vision of the individual subject (the person who had the experience or the historian who recounts it) becomes the bedrock of evidence on which explanation is built. Questions about the constructed nature of experience, about how subjects are constituted as different in the first place, about how one's vision is structured – about language (or discourse) and history – are left aside.[10]

I am most interested in how 'vision is structured', in how ideas and practices come to influence what is possible and explicable behaviour, and how these change. This is not to demean patients or their stories, experiences or identities, but to say that this history attempts something different. The patients and their experiences recede in this telling, as do the psychiatrists to an extent. What is left are practices, arrangements, ideas, concepts – all the things that recur in psychiatric journal articles and government documents. This, like all history, must resemble its sources, but remains useful – hopefully to people other than myself – because it enables new connections to be made around self-harm, society, psychology and politics. It might make the various individuals involved in the story less visible (in terms of their experiences), or flatten them out to their research contributions, but it also allows new links: between categories of identity and the rise of professional groups; between broad political contexts and clinical categories; between an intellectual climate in psychology and psychiatry and the ways in which we understand self-damaging behaviour; between politics and the ways in which people understand themselves and their identities.

The rise of neurology

To return to specifics, we see that self-cutting is both a residual and a newly emergent category. It is understood – gradually and unevenly – as a method of affective self-regulation rather than social communication. This opens the way to neurological explanations of the behaviour. This happens because neurological explanations focus upon the individual's nervous system as a privileged site of understanding. The reason that it is only a small step from 'individual tension' to 'neurochemistry' is that both approaches, or concepts, take the individual at their starting points. A communicative attempt, in contrast, focuses upon a social situation in which various people are embedded. However, even this contrast has recently become unstable, as there is work that investigates the 'neurology of social cognition' as well as sociological work on the discipline of neuroscience (upon which this book has drawn).[11] However, the point stands that internal emotional turmoil maps much more easily onto neurological understandings than does psychosocial communication.

Although the neurochemistry of complex behaviour is widely acknowledged to be in its infancy (a claim also made in the mid-1970s), there are a number of guiding principles that underwrite these perspectives. Regardless of the particular system or neurotransmitter that is implicated, these sorts of studies are all based around the assumption that neurochemistry is at the root of the behaviour, and operates prior to culture, and is indeed, outside culture. As Hilary and Stephen Rose argue with respect to molecular biology: 'Again and again the molecular biologists leading the sequencing [of] the human genome [between 1990 and 2013] claimed that the completed genome would constitute human identity'. They add that 'The neurosciences have not been left behind; their claims to explain selfhood, love and consciousness as located in certain brain regions ... have been articulated in a string of popular books'.[12] Given the audacity and ambition of these claims, it is unsurprising that neuroscience and neurobiology are increasingly utilised to investigate the (comparatively modest-sounding) self-cutting-as-tension-release in order to reveal its neurological basis.

Michael Simpson is among the first to speculate upon a biological basis for the behaviour of self-cutting in 1976, but he is notably cautious in ascribing the behaviour any secure biological basis.[13] In 2001, Fiona Gardner (a psychoanalytically trained therapist) writes in a cautious and equivocal vein about 'self-harm':

> [T]he behaviour can be coercive, in that self-harming produces a wanted response from others; second, it is relieving, in that the action produces a lightening of mood, either through biochemical alterations and the associated release of endorphins (the body's own analgesics), or conditioning, or symbolically.[14]

She mentions social ('coercive') explanations, followed by biochemical, classical conditioning and symbolic understandings. These cautious studies exist alongside publications by such as Schroeder, Oster-Granite and Thompson's text, *Self-Injurious Behavior: Gene-Brain-Behavior-Relationships*, published by the American Psychological Association in 2002, and which pushes much harder to understand behaviour in terms of the brain and genetics.[15] In the 2010s, there is increasing recourse to neurochemical and biological explanations to explain 'self-injury'. David Brent, in a recent editorial for the *British Medical Journal*, sees self-injury as 'most commonly used as a mood regulation strategy ... thought to relieve negative affect through the release of endogenous opioids'. Whilst Brent does argue for the relevance of the social context, he also maintains that the difference between suicide and self-injury can be established with reference to neurochemicals: 'Although nonsuicidal self-injury and suicide attempts often occur in the same individual and share some common risk factors, their motivations, reinforcers, and neurobiology are distinct'.[16] This is an explicit attempt to separate suicidal behaviour and self-injury, not simply in terms of motive but in terms of a distinct neurobiological pattern. In addition, as emotions and moods are increasingly understood in neurological terms, so self-injury becomes enmeshed in neurological explanations. For example, as borderline personality disorder (closely associated with self-injury) is understood through neurochemical frames of reference (e.g., neuropeptides), self-injury is increasingly 'neurologised' by association.[17] Efforts have also been made to associate self-injury and suicidal behaviour with the neurochemical serotonin and the serotonergic system.[18]

However, there also exists considerable circumspection amongst the more prominent psychological experts on self-injury about how much this behaviour might be reduced to biological bases. Favazza is sceptical of neurology and neurochemistry – as might be expected of a 'cultural psychiatrist' whose undergraduate degree is in anthropology under Margaret Mead. He notes that there may be a swing back towards analyses that focus upon the social or cultural environment: 'although psychiatry is focused on the primacy of cellular, genetic and neuronal approaches, there is a growing recognition that culture cannot be

ignored'.[19] To him, it is clear (in 2011) that cells genes and neurons are at the forefront of conventional explanations. In a similar vein, sociologists Adler and Adler are clear about their desire to 'demedicalise' self-cutting, understanding it instead through sociological concepts such as deviance and social reinforcement.[20] It should be noted that sociological and psychological explanations persist – based upon learning and peer-group influence, and yet remain based upon ideas of emotional regulation. This is not a simple dichotomous split. However, over the past decade there have been many efforts to understand self-harm through neurochemical and neurological frames of reference. Health communications scholar Warren Bareiss concludes that media narratives of self-injury consistently downplay possible social causes of self-injury in favour of a model that understands self-injury as a personal choice.[21] This idea of an individualised, personal choice meshes well with neurochemical understandings, as well as with market-based ideology that is centred upon a rational, autonomous consumer.

This is a complex and nuanced picture, where social – and sociological – explanations can co-exist with ideas of internal tension and can also feed into neurological explanations. There is no easy way to sum them up. However, we can be more certain about the shifts at the heart of this book: that the archetypes of self-damage from the 1930s to the 1980s have undergone radical transformations. This corresponds to local, mundane and administrative innovations, but also feed off and feed into much broader political constellations. It is to these that we now turn.

Neo-liberalism, individualism and biomedicine

The broad political picture in the United Kingdom between 1945 and the end of the 1970s is conventionally thought of as characterised by consensus politics, commitment to welfare and significant nationalised (collective) ownership of industry (including transport, communications and health care). Such a collective outlook corresponds with the 'local picture' drawn in this book, consisting of a psychological perspective that is acutely aware of collective social life, communication and the embedded nature of human beings in their particular social contexts. This consensus politics is displaced from the late 1970s by a world view in which the family retains its importance, but there is much more of a focus on individual competition and self-discipline.

In general, neo-liberal thinking is based upon the primacy of market forces and the desirability of individual competition. Efforts to provide

collectively are seen as stunting the individual's competitive edge. This perspective on human life has its roots in the political philosophy of Friedrich von Hayek and the economics of the 'Chicago school', linked-with Milton Friedman and his associates and students. In Britain, this approach is most closely associated with the three governments headed by Margaret Thatcher between 1979 and 1990. It has been labelled 'neo-liberalism' due to its stress on the old liberal values of economic freedom and self-reliance. Roger Cooter describes it as 'the anti-Marxist philos-ophy-cum-ideology founded on a view of human nature as entirely self-interested and incapable of thinking beyond "the market," which it constructs and sells as an autonomous force'.[22]

Journalist Andy McSmith's popular history of the 1980s, *No Such Thing as Society*, takes as its title the immortal words uttered by Margaret Thatcher in an interview with *Woman's Own* magazine in 1987. In full context, Thatcher argues:

> I think we've been through a period where too many people have been given to understand that if they have a problem, it's the govern-ment's job to cope with it. 'I have a problem, I'll get a grant'. 'I'm homeless, the government must house me'. They're casting their problem on society. And, you know, there is no such thing as society. There are individual men and women, and there are families. And no government can do anything except through people, and people must look to themselves first. It's our duty to look after ourselves and then, also to look after our neighbour. People have got the entitle-ments too much in mind, without the obligations.[23]

This is an exceptionally clear message that social problems (such as homelessness) should no longer be the preeminent concern of the state but of individuals (and in fact the individuals who are homeless). It displays a clear shift from a governmental responsibility for social prob-lems to individual responsibility. We move from the social to the indi-vidual. This can be usefully contrasted with Erwin Stengel's concern, quoted at the start of Chapter 3, about a 'society which has made every individual's welfare its collective responsibility'. In one sense, Stengel and Thatcher are worried about the same thing: the burden that the exploitative 'few' might exert on the hardworking 'many'. However, Stengel seems broadly to accept such a state, whilst Thatcher seeks to dismantle it.

As McSmith makes plain, this is an economic policy as much as anything else. Thatcher is congratulated upon the Conservative victory

in 1979 by economist Milton Friedman (soon to become policy advisor to Ronald Reagan) in a rather grandiose exchange. Friedman gushes: 'Britain can lead us all to a rebirth of freedom – as it led us all down the road to socialism'. Thatcher replies: 'The battle has now begun. We must win by implementing the things in which we believe'.[24] McSmith also makes abundantly clear that the 'no such thing as society' sentiment is present in Thatcher's thinking in the late 1970s (and not just the late 1980s when it appears). He cites handwritten notes for a 1979 speech proclaiming 'no such thing as collective conscience, collective kindness, collective gentleness, collective freedom'.[25] Her abhorrence of the collective and the social, and her championing of the individual, maps well onto the shift from social communication to internal emotional regulation.

Michel Foucault's lectures at the College de France in the late 1970s contain a sophisticated discussion of neo-liberalism and its significance. He notes that it emerges in two distinct places, in similar forms: a German form, linked to a critique of Nazism and the post-war reconstruction and an American form, defined in opposition to Franklin D. Roosevelt's 'New Deal' and the federal interventionism of the Democratic presidential administrations of Harry Truman, John F. Kennedy and Lyndon B. Johnson. Foucault argues that these forms are united by 'the main doctrinal adversary, [economist John Maynard] Keynes ... [and] the same objects of repulsion, namely, the state-controlled economy, planning, and state interventionism'.[26] According to Foucault, the state is reconceptualised as the guarantor of economic freedom, but more than that:

> Since it turns out that the state is the bearer of intrinsic defects, and there is no proof that the market economy has these defects, let's ask the market economy itself to be the principle, not of the state's limitation, but of its internal regulation from start to finish of its existence and action. In other words, instead of accepting a free market defined by the state and kept as it were under state supervision ... [instead] adopt the free market as organizing and regulating principle of the state, from the start of its existence up to the last form of its interventions ... a state under the supervision of the market rather than a market supervised by the state.[27]

Given the huge range of commentators on this shift, I here take just three other examples almost at random, for illustrative purposes. Perry Anderson's collection, *Spectrum*, analyses the writings of diverse political thinkers, and his appraisal of Ferdinand Mount (active in writing

Conservative Party policy in the 1980s, including the General Election Manifesto of 1983) is that the Labour Party's 'construction of a welfare state, technocratic in design and bureaucratic in delivery ... is the consistent object of Mount's dislike'.[28] Butler's and Drakeford's analysis of social-work scandals in twentieth-century Britain characterises the Conservative governments of the late 1980s and early 1990s as 'redefining the welfare state in such a way that a premium was attached to notions of individual rights and personal freedoms'.[29] Rose and Rose argue that successive governments from the late 1970s onwards begin 'enthusiastically exchanging the political economy of the welfare state for that of neo-liberalism. The rise of transnational corporations, able to spread production processes across countries ... together with the attack on organised labour, began to sap the very foundations on which the welfare state was built'.[30] Here we have the core of neo-liberalism: individual rights, antipathy towards the welfare state and organised labour, and a stress upon self-reliance rather than collective provision.

This political shift broadly coincides and intimately corresponds to the much more individualistic reading of self-damage, based upon emotional self-regulation. Indeed, neo-liberalism's stress on individual actors' radical freedom to make choices for their own benefit fits well with a model of self-harm that emphasises the individualistic, private feelings of tension, and the self-regulation of these through cutting. The coincidence of neo-liberal political ascendency from the early 1980s in the United States and United Kingdom, and the displacement of the social setting from understandings of self-damage are not chance occurrences.

In a similar vein to this book, Gillian Harkins analyses the shift from a welfare economy to neo-liberal one in terms of the emergence of certain human categories of behaviour. She connects the socio-economic shift to neo-liberalism to an emergent concern about predatory paedophiles:

> Harkins links the way in which we have constructed the paedophile as the ultimate monster to the vilification of the state as the enemy of the free market. Each form of discourse is linked to, and helps support the other, through a shared model of human nature and its interests. The state and the paedophile [are] depicted as stealing the natural potentiality of the child.[31]

So here we can see the ways in which apparently independent phenomena are linked to broad political changes, perhaps counter-intuitively. The figure of the paedophile and the new vision of a suffocating

state are founded upon the figure of the child and its potential. Harkins expands upon this link, claiming: 'Older modes of social security ... will be replaced by demands for a new type of "security" in the face of universal danger [the paedophile]. This security operates through the proliferation of risks and controls rather than the enclosure of disciplinary space'.[32] Thus Harkins sees a shift from enclosed, family, social spaces, to a much more diffuse and distributed space. This is analysed and developed through the varied categories and objects that populate our lives. In the same way, the rise of self-cutting as based upon autonomous, self-regulating individuals pushes out a reading of socially embedded, collective responsibility for psychological distress. No longer is pathology redistributed onto spouses or social relations (in Thatcher's terms 'casting their problems on society') – it is internal, individual and self-regulated.

The relationship between the two outlooks and their different scales (macro and micro) is complicated and rather opaque. It is approaching the banal to say simply that they feed off each other and correspond to each other. This sentiment might be developed by arguing that from the infinite possibilities of human behaviour, only a small number ever congeal into perceptible objects and are labelled as traits, syndromes or patterns. We see with self-cutting that a large number of other behaviours (such as swallowing objects, smashing windows, paroxysms of rage or social imitation) are consistently downplayed in order to produce a comprehensible object. In the same way, self-poisoning as communication neglects internal psychological states in favour of charting the psychological significance of the environment. In a general sense, these objects rely upon the intellectual and institutional conditions, where they are studied and from where they are publicised (secure inpatient facilities, A&E, counselling services, psychoanalytic interviews, and so on). The objects that appear from these settings can then be regulated, studied or managed (by government memoranda, informal referral arrangements, or specially designed questionnaires). If that management is removed or undercut (by a rethinking of the responsibilities of the state), then the objects fall from view, leaving space for others. These new objects are more likely to attain prominence if they resonate with other changes going on in the political sphere.

But it is important to remember that mundane arrangements like the fracturing of psychiatric scrutiny on self-poisoning in 1984 are just as important – and certainly more accessible to historians who seek to explain change. In a similar vein, Waldenberg's (1972) refocusing

attention away from communication (and its association with 'attention-seeking') is part of his strategy for dealing with nursing staff's 'grumbling' about self-cutting patients. In order to promote the care of these patients in ways he considers appropriate, he emphasises internal tension. These arguments remain important today, in the politics of deliberate self-harm. Labels such as 'attention-seeking', bandied about by the media, tend to trivialise the behaviour, so clinicians who are interested in taking it seriously and treating it might become wary of discussing or emphasising 'communicative intent'.[33]

We have discussed the resonance that self-cutting as tension-release has with neo-liberalism, and also that between self-cutting as tension-release and neurochemistry/biomedicine. We can complete that particular triangle of associations by briefly discussing the resonance between technological biomedicine and neo-liberal economics. As Kaushik Sunder Rajan argues in *Biocapital*, 'the life sciences represent a new face, and a new phase of capitalism and, consequently biotechnology is a form of enterprise inextricable from contemporary capitalism'.[34] Rose and Rose follow a similar line of thought, arguing that 'the life sciences have been transformed into giant biotechsciences, blurring the boundaries between science and technology, universities, entrepreneurial biotech companies and the major pharmaceutical companies, or "Big Pharma"'.[35] So the welfare state is rolled back, individualism and self-reliance are stressed, capitalism becomes largely unregulated, biotechnology flourishes and, self-damage as response to a social setting is displaced by self-damage as self-regulation of internal tension. This internal tension is then significantly (though not totally) 'biologised' and rooted in brain biochemistry. A detailed study of the interactions between these threads is for another book. What I want to emphasise here is that the mass of labels and psychological objects that populate our lives do correspond to wider political contexts. Self-poisoning as a cry for help is largely invisible today (even as self-poisoning numerically dominates A&E statistics for self-harm) partially because the embedded, funded and self-evident awareness of social contexts has largely disappeared from the political mainstream.

Neurology and neo-liberalism are also linked through their wholesale forgetting or belittling of the social context. In fact, it is this determined omission that gives both neo-liberalism and the turn to neurology their fundamentalist zeal. It serves as fuel for its evangelising of the revealed neurological, or competition-based eternal truths of human nature. To quote Rajan again: '[C]apitalism, which is triumphantly acknowledged today as having "defeated" alternative economic formations such as

socialism or communism … is therefore to be considered the "natural" political economic formation'.[36] This is not to belittle neuroscience or capitalism in a tit-for-tat battle as neurologists and neo-liberals attempt to cast 'the social' as irrelevant. Nor is it to claim that neurochemistry has no impact upon how humans behave: Who could doubt the influence of the body upon the mind? The thing that baffles and unnerves me in equal measure is the refusal of some to countenance that this embrace of neurology is itself a culturally, socially situated phenomenon. The ways in which we search for a handle on human nature change over time, and are parts of humanity's socially influenced, culturally saturated existence. The claims of science to be beyond culture, to be a method by which unarguable truth is revealed, begins to sound more and more theological the more entrenched it gets. It also fails to see how the ways in which science considers itself beyond cultural contexts and biases – the complex notion of objectivity – have themselves changed over the centuries.[37] The idea that laboratory science lives up to its self-billing as a controlled, bias- and culture-free environment has been convincingly demolished for some time.[38]

There is of course a level of circularity in arguing that various social (and practical) contexts can explain the fluctuating fortunes of the social context. These arguments are just as historically specific, and deserve some reflection and analysis. Part of the answer is that I seek to analyse what counts as truth in different historical periods. However, this does not answer the question of why I have written an account that focuses partially upon a social context (in the form of intellectual climate in psychology and psychiatry) in order to explain the rise and fall of a socially focused medical category. This might be clarified by explicitly stating my motives for writing this book. I feel deeply uneasy that neurological and neo-liberal explanations (including ideas of human nature, as much as economic policy) are ascendant, to the detriment of socially aware, collective approaches that emphasise the environment and the interpersonal parts of human existence.[39] Market forces, competition and the roll-back of the welfare state – and the acceptance of inequality that this entails – constitute the foundation for mainstream politics in England today. The Labour Party, the founders of the welfare state, are fully signed up (post-2010) to the necessity of 'austerity', and arguably abandoned Keynes in the early-mid 1990s. Their current position seems to be that they would roll back the state just a little more slowly than the Conservative party.[40] (The recent election of 'anti-capitalist' party, Syriza, in Greece might signal a fracturing of the neo-liberal consensus, but it is too early to tell.)

On one level, this history of self-harm is about the organisation of therapeutic approaches and professional practices within health-care systems. In this sense, it has attempted to show how analysis of these areas remains critically important to understanding how and why health epidemics emerge. This account of the establishment and reinforcement of a behavioural pattern also has more intimate consequences. What humans can do, how we experience our emotions and perceive our possibilities – these are fundamentally contextual, situated issues. The turn to social, relational ways of understanding mental health and illness dominate the possibilities for personhood in the middle third of the twentieth century.

The broad point of this book is to show how these possibilities for action or self-experience might come about, and (very briefly) how they might fall away. It is concerned chiefly to reconstruct the intellectual and practical environment where human self-damaging behaviours are chiefly interpreted as communications with a social circle, a cry for assistance and help, in a political climate where there exists considerable consensus about the weight of society's responsibility to provide in a collective manner for the welfare of its citizens (the collective health-care and social-security arrangements referred to as the 'post-war settlement'). It is because that consensus is so thoroughly overturned and almost discarded in the years after 1979 that this book can be seen as politically motivated. The collective aspect of human life is being forgotten in these neurological and neo-liberal reimaginings of human nature.

By using the example of self-damaging behaviour, we take an example that seems to have very little relation to politics (as conventionally conceived), and show how this scientific, clinical object is bound up and implicated with the much larger currents that ebb and flow in the wider culture. These are fuelled on a local level by seemingly mundane practical arrangements, but are no less affected and shaped by the broader intellectual climate. Broad administrative, therapeutic and legal structures interact with local, credible, conceptual and practical labour. This interaction demonstrates the crystallisation and reinforcement of particular intelligible behaviour patterns from infinite possible combinations. This book shows how attempted suicide as communication becomes an available human behaviour pattern at a certain point in history, and how it subsequently becomes displaced. To understand how it is that we act as human, self-conscious beings, we must analyse how the possibilities for comprehensible actions are made. At the same time, we must link these possibilities to the broad political constellations from which

the academic humanities seem to be retreating. We must take a position on the ascent of neo-liberalism, as its language of market-friendly research, financial worth and impact continues to take root in academic management. Politically and intellectually, it is a mistake to attempt to explain human complexity, human behaviour and human society through either simplistic market models or flattened biological or evolutionary ones. This is not just because they fail to capture and explain human behaviour in a nuanced and credible way, but also because they are closed systems. They do not allow for their fundamental premises to be questioned or challenged.

Instead, we might affirm the contingency of all explanations, and view with scepticism all claims to unarguable truth. This does not entail political paralysis, but instead invites criticism of what is given or taken for granted in a political (or historical account). At present it is 'given' that any interference with the market creates damaging inefficiencies, that people cutting themselves are responding to internal feelings of tension, that we must 'balance the books' with austerity measures, that our brains hold the key to our selfhood. All of these assertions require constant engagement, criticism and debate.

The point about contingency and scepticism also includes this book. It is written after the 2008 economic crash and bailout, and during the election in Britain of a coalition government of Conservative and Liberal Democrat MPs who are ever more committed to slashing public budgets along with collective responsibility for social problems. In this particular context, it becomes clearer why the text might painstakingly reconstruct a time where the social setting and social interventionism is taken for granted. It establishes a contrast with what is considered so natural in the present (of 2015). Another context concerns funding. The PhD research which forms the basis for this book is funded – made possible – by the Wellcome Trust, a former pharmaceutical company, now a charitable foundation with huge interests in biomedicine and neuroscience as well as in the history of medicine (now more broadly conceived as 'medical humanities'). Indeed, this book is freely accessible on the Internet because of the Trust's generous Open Access (OA) policy to those it funds. My engagement with politics is through the lens of the history of medicine and psychiatry, partially because that falls within the charitable remit of the Trust. This does not mean that I am overplaying or exaggerating the influence of connections between psychiatry, medicine and politics. It simply means that this book (in its present form) would not have been written without the Trust's support. This also needs to be taken into account when weighing the book's

contribution and the importance of its emphases and exclusions. I am no more outside my context than the psychiatrists and social workers I study are outside theirs. Money, funding, intellectual fashion – all the things that we willingly forget or skim over when writing academic material – they still matter.

Finally, it is important that reconstructing and analysing the underpinnings of a category based in a social setting is not the same as glorifying or even agreeing with high levels of social intervention. Social work interventionism can lead to horrifying scandals such as that in Cleveland in the North-East of England in the 1980s. Large numbers of children are removed from their families because of allegations (and evidence) of sexual abuse that turn out to be unfounded.[41] So this book is not calling for a 'return to the social' – even if that were possible. It is written instead to call for awareness of the contingency of these organising frameworks. Only by keeping this in our minds can we reach a new consensus where we can weigh our individual and collective responsibilities in a more equitable way. We need to see that the decline in credibility of the social setting, and its replacement by internal self-regulating individuals is among the countless ways in which humans make and remake their worlds (including our ideas of self-damage). The self-evidence of these clinical, psychological and political objects makes them seem natural. This then serves to naturalise the context in which they function – market-based neo-liberalism. If we can see these objects as the result of human actions and human conceptual frameworks, it becomes possible to see that the consequences of the neo-liberal inequalities that assail our society are up for ethical discussion – they are not simply 'human nature' or 'inevitable'. They are, instead, the result of our actions: if we make and accept contexts where inequality is naturalised, then we can also put our efforts into unmaking and refusing these same contexts, and those inequalities.