OPEN

Introduction: Self-Harm from Social Setting to Neurobiology

Self-harm is a significant mental health issue in the twenty-first century. The recorded rise in various behaviours, including deliberate self-cutting and self-burning, have been widely remarked upon and lamented.[1] Eminent cultural historian Sander Gilman has recently written of a global 'sharp public awareness of self-harm as a major mental health issue'.[2] The behaviour is usually said to be motivated by a desire to regulate feelings of intolerable tension, sadness or emotional numbness, and is almost always reported to be 'on the increase'; it is also often reported as a problem primarily affecting young women.[3] Despite a steady stream of books and articles on this emotive subject from the 1980s onwards – from psychiatrists, social workers and sociologists among others – there remains little meaningful historical analysis of this phenomenon.

This book sets out to provide such a history of self-harm in Britain in the twentieth century. It argues that to cast self-harm as an innate, eternal or transcendental practice (as much of the current literature does) is not helpful, historically speaking.[4] In fact it is decidedly ahistorical, as the core motivations underlying the practice of self-harm are seen as outside of history. This book shows how clinical ideas and medical diagnoses (such as 'self-harm') are intimately related to the specific, practical contexts in which they emerge and function. It also shows how shifts in concepts of self-harm correspond to much broader political trends. The central political shifts in this book are the ones that bring the welfare state into being after 1945, with nationalised industry and commitment to collective provision in housing and healthcare. This corresponds to an understanding of self-harm (overdosing) that is collective, communicative and socially embedded. The roll-back of the welfare state in the 1980s, coupled with the ascendancy of a more

individualised understanding of human beings as competitive and market-driven, corresponds to an understanding of self-harm (self-cutting) that is read as largely non-communicative and designed to regulate internal emotional states.

This book recovers and reconstructs, in detail, a clinical concern over an epidemic of overdosing presenting at British general hospitals between the early 1950s and late 1970s. This action is seen to be a response to, or communication with, a social circle or another person. This particular epidemic is part of a shifting chain of ideas about self-harming behaviour. These shifts partially come about through changes in the type and intensity of psychological and psychiatric attention focused upon self-inflicted injury (mostly overdosing) presenting at general hospitals. Self-cutting as a means of reducing internal tension emerges in very different circumstances – psychiatric hospitals dealing with inpatients – and is significantly influenced by North American psychoanalytic approaches. Once this archetype of self-harm is established, it begins to make sense as a model for the small minority of self-cutters (approximately 5–10 per cent) who present alongside the majority of overdoses at Accident and Emergency (A&E) departments in Britain. This book shows how dominant ideas about self-harm have gone through three broad phases during the twentieth century. From being seen in the early part of the century as a largely uncomplicated attempt to die, to a pathological communication with a social setting in the middle third of the century, to a method of regulating internal psychic tension that exists today. More recently, self-harm as tension reduction has begun to be understood in neurochemical terms, especially the notion of neurological triggering, as setting off an episode of self-cutting.[5]

The shift from understandings based upon social settings to ones based upon internal tension is of considerable political importance, given how it coincides with the collapse of consensus politics, the ascent of neoliberal economics, and the roll-back of the welfare state in the 1980s. It is a central contention of this book that the ways in which we make sense of our worlds, the categories and concepts that are available to understand human behaviour (such as self-cutting), resonate with and correspond to larger political constellations. The objects that seem so natural – that seem to have an independent, common-sense existence – are not outside of culture, politics, or ethics. In order to better understand this shift, this book reconstructs the middle phase of self-harm, alongside some stereotypes that preceded and succeeded it for comparison. Thus, the book aims to draw in detail an explanation of self-harm that relies upon the 'social setting'. This will establish a striking contrast with

an explanation that has displaced 'the social' with explanations based on internal emotional states – which become increasingly expressed in neurological terms.

The idea that somebody might damage themselves as a communicative act emerges in an influential way during the 1950s. Increased provision of psychological expertise at general hospitals makes available the explanation that people deemed to have harmed themselves might in fact be communicating in a psychologically disordered manner. The self-harm is predominantly achieved by 'overdosing' – taking medication in quantities considered excessive, but rarely lethal. Most studies of this phenomenon in the 1950s retain the term 'attempted suicide', whilst also emphasising that death is not the intended outcome for most patients. However, in the 1960s and later a large number of new terms are proposed by psychiatrists and doctors to try to deal with the confusing idea that 'attempted suicides' are not actually attempting suicide. Terms such as 'self-poisoning', 'parasuicide', 'pseudocide' and 'propetia' (rashness) are all put forward in order to deal with this confusion. However, the most common throughout the period remains 'attempted suicide'. The prominence of this supposedly communicative act increases in step with the level of psychiatric expertise available to general hospitals. This includes explicit efforts by the Ministry of Health to promote referral of attempted suicide patients to psychiatrists after suicide attempts are decriminalised in 1961.

This clinical and public-health concern begins to diminish in prominence from the late 1970s onwards. The generic category 'self-harm' comes increasingly to refer to self-cutting, seen not as a communication or appeal for help, but as a method of regulating internal tension or dispelling a sense of emotional deadness. It has recently been argued in a review of non-suicidal self-injury that whilst communicative and interpersonal models have been proposed, 'the affect regulation hypothesis has received the greatest amount of empirical support'.[6] Thus, the archetypal meaning of the label 'self-damage' or 'self-harm' shifts from self-poisoning as a communication, to self-cutting (and burning) as emotional control. Overdoses are now broadly conceived (outside of casualty-department-based epidemiological studies) as genuine attempts to end life.

To take just two examples of this displacement, the influential cultural psychiatrist Amando Favazza defines self-injury as: '*the deliberate, direct, alteration or destruction of healthy body tissue without an intent to die*. This construct excludes excessive dieting, pathological anorexia, acts committed with an intent to die, overdoses or ingesting objects and

substances, body sculpting by drugs or weightlifting, risky behaviors, and cosmetic surgery (a topic for another book)'.[7] Thus overdoses (along with many other practices) are excluded. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) includes a discrete self-harm category for the first time (rather than self-harm figuring only as a symptom of other disorders); 'Non-Suicidal Self-Injury' is described as 'intentional self-inflicted damage to the surface of his or her body', which again rules out overdosing.[8]

During the late 1990s there emerge several analyses of the ways in which the social setting has been displaced – including Nikolas Rose's provocative question around the 'death of the social'.[9] Roger Cooter has recently written that when 'humanness is flattened to the biological, the salience of the social disappears altogether'.[10] Sociologist Michael Halewood tentatively argues that scholarly discussions of '*the* social' only begin to appear in the early 1980s (for example Jean Baudrillard's work), when chronicling its supposed decline.[11] This fits in broadly with the chronology advanced here. The present book analyses one part of the idea of 'the social' as it is conceived and fabricated around an act of self-harm. I do not pretend to exhaust all possible concepts of the social, but such a narrow approach enables a clear idea of one particular and influential 'social setting', showing how it comes into renewed focus after 1945 and is then displaced from the 1980s onwards.

Analysis of the short heyday of overdosing as self-harming communication – between the early 1950s and late 1970s – can show how clinical objects are fundamentally tied up with the administrative practices and conceptual frameworks available at certain points in history. Important light is thus shed upon the relationship between the seemingly self-evident objects that populate our daily lives and larger shifts in the dominant explanatory frameworks in any given cultural system. This book is based primarily on the study of psychiatric research publications. The predominant focus is therefore on the ideas of psychiatrists and the clinical and administrative practices they describe. However, the broader political context and its resonance (especially around welfare and collective social responsibility) should not be forgotten and is flagged up where appropriate. The short career of this epidemic illustrates a far-reaching shift, from social and communicative understandings to ones based upon internal emotional tension, and then on to neurological ones. We must be clear about the ways of thinking that we are leaving (have left?) behind if we are to engage in an informed, ethically aware way with these changes. Self-harm presents an opportunity to track the ways in which certain influential understandings of behaviours are

embedded in, and help to structure, their varied historical contexts. Such broad contextual and conceptual shifts have important political consequences – we must bring them into focus, undercutting their status as natural or 'common sense' – before we can engage with them politically, ethically and morally.

By linking attempted suicide and self-harm in this way, it might be argued that I am confusing or mixing up phenomena that should be kept distinct: attempted suicide should not be mixed with deliberate self-harm, or self-cutting should be understood as distinct from overdosing, to take two common objections. However we must not presume today's categories to be eternally valid. Instead of taking current categories at face value, this book analyses how the various assertions of difference and stereotypes come into play and how they are transformed over time.

The overarching aim of this book is to show one of the ways in which we have lost certain social, interpersonal perspectives in favour of individualised explanations based upon internal emotional states. It places professional, clinical analyses of this behaviour into detailed historical context, drawing upon the approaches of historical philosophers Michel Foucault and Ian Hacking. This 'genealogical' method seeks to analyse the rise of these behaviours and behaviour categories by connecting them to wider historical, intellectual and administrative contexts. It draws upon Hacking's insight about how people come to experience themselves through the concepts available to them at a particular point in time – what he calls 'making up people'.[12] This book charts the making up (and then part of the unmaking) of a certain type of attempted suicide, a cry for help, in a specific historical context. The idea that an informal arrangement attaching a psychiatric consultant to a casualty department, for example, could become an important part of a national public health problem seems counter-intuitive. However, it is this mix of small shifts (what Foucault terms 'micro-physics' or 'capillary power'), with an awareness of the overarching intellectual approaches of the time that shows how the ways in which we make sense of the world are continually shifting.

As well as its concern with reconstructing the social setting around self-harm in order to further emphasise its relative absence in the present, this book attempts three other interventions in the history of medicine. These are, broadly: to complicate the shift in psychiatric care from asylum to community; to analyse the role of the law in mental healthcare; and to explore the production of gender roles and sexism in mid-twentieth-century psychiatry. This book challenges current understandings of the

history of psychiatry by interrogating the supposed move from 'asylum' to 'community care'. This shift is usually traced back to (then health minister) Enoch Powell's 'Water Tower' speech in 1961. Here, Powell casts the mental hospital ('isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined') as a relic of the past. Instead, he claims, care for the mentally ill is better provided in 'the community'. (This model of care is much cheaper; as the asylums are phased out, no new money is earmarked for investment in community services.)

This binary of asylum-community underplays the mental healthcare provided at general hospitals. It is in these institutions that attempted suicides are treated for the physical damage but increasingly, as the century progresses, for the mental side of treatment, too. There are complicated interactions between mental and physical medicine inside general hospitals – through separate psychiatric wards, mixed wards, mental annexes, consultant and liaison psychiatrists and mental observation wards (something of a relic from the old poor law/workhouse hospitals). Through these varied institutions, mental medicine evolves in ways that are simply not captured by the tired binary of 'asylum-community'. Self-harm is perfectly placed to disrupt this simplistic but enduring attitude to the history of mental healthcare in the mid-to-late twentieth century.

This book not only revises understandings of the history of psychiatry in general, but also shows how legal changes and mental-health policy are absolutely crucial to the visibility and impact of these self-destructive behaviours. It shows how the Mental Health Act (1959) and the Suicide Act (1961) are linked. The former removes all legal restrictions for the treatment of mental illness in general hospitals; the latter decriminalises suicide and attempted suicide. Both are rooted in the same concern for appropriate psychological treatment without legal intervention as far as possible.

Finally, this account of self-harm analyses stereotypes of the actors supposed to perform the behaviours, with predominant focus on overdosing. Overdosing becomes highly gendered. The idea of an overdose as a cry for help draws upon ideas of feminine manipulation and emotional blackmail. The subsequent gendering in 'self-cutting as tension regulation' works slightly differently, feeding off the idea that men project their anger outwards, whilst women focus inwardly upon themselves (an outward/inward divide that has significant debts to conventional sex-role stereotypes). Deliberate self-harm has also been explained as a result of the stresses on women entering the workplace or, as it was put

in a 2009 documentary, women trying to 'have it all' from the 1970s onwards. These antifeminist and often outright misogynist assertions have been critiqued elsewhere regarding self-cutting, but not for overdosing, hence my focus on the latter.[13]

A note on the present tense

This book is written entirely in the present tense. To write in this way is a tactic, with an objective, in the same way that writing history in the past tense is a tactic. These choices are tactical because they suppose – or at least imply – a particular relationship between 'history' and 'the past'. The past might be defined – relatively uncontroversially – as 'things that have happened before now'. If this is conceded, then history is not about the past. If we see 'the past' as the things that happened before today – indeed all things that have happened before today, before this moment – then what we are talking about is practically infinite, a senseless mass, a morass of impossible detail, of inhuman complexity. The past conceived in this way is an idea, but also a limit: it defines the present by continually pressing up against it and by swallowing up every possible human event, action or thought as soon as it has happened. We cannot speak about 'the past' as a whole entity – where could we start, let alone end? We can only talk about parts of the past. We can abstract from it, mobilise it, deploy it, use it. By making it partial, by editing, omitting, emphasising, glossing over, unpicking and ignoring the vast majority of the past, we can make it comprehensible, turn it into a story. This is the basis of history – making stories, making sense out of the past. This much is also uncontroversial, at least in academic history, since the early twentieth century. But even this obscures something and achieves something. For the past is not 'sitting there' waiting to be dug up, or analysed, or unearthed. It exists because we or others have put a marker down, because we are conscious of things having happened. Because we make a gesture of differentiating 'now' from 'then'. It is only after this differentiation that we can say the past is 'there'; it is only 'there' because we are 'here' in the present.

And this is the point of this lengthy discussion: we make 'the past' by acting in the present. We continually make and re-make the past. But more than that, we make the past by doing history – history begins with that differentiation between the past and present. Historians must clear the ground so that they can speak. They (we?) do this in the present, according to present concerns, with their (our) present tools, with their (our) present capacities, vocabularies and ideas. The past

is an idea that is projected by history. The past is also the foundation stone that we all lay in order to recount our biographies, our very sense of self. But, depending upon where we are in our lives, these histories are different. The conceptual vocabularies we have emphasise different things; different things become visible and available. Child guidance, psychoanalysis or attachment theory impress upon our lives a very different sense to that given by evolutionary psychology or genetics. In the former, the events that loom large in history are those of our early upbringing; in the latter we focus on an entirely different order of time – a different history – to explain the roots of events. Our present choices, our present possibilities are pushed into a past tense that implies fixity, solidity or stability, when in the very next moment new events or new conceptual frames could overturn that whole edifice. The present tense is deployed to avoid this implication. It emphasises that the story being told is being told in the present, according to the present concerns, and under present constraints.

To tell these stories in the past tense risks the implication that they are fixed: that they are gone, done, dusted and immutable. The present tense is unsettling because we are so used to thinking of the past as 'over'. But history is never over; it is always about the present. Paul Connerton writes that we 'experience our present differently in accordance with the different pasts to which we are able to connect the present'. This is undoubtedly true. But the reverse is also true: the pasts that we are able to connect to the present depend upon the material, intellectual and social conditions of that present. History is thus made in, and governed by, the conditions of the present in which it is created. History is the present use of the past.

To claim that history is about the past and not the present is to make a mistake, to confuse a claim for authenticity with a statement of ontology. In less technical language: we should not take it on trust that history is (its ontology) what it claims to be. History gains much power and prestige by laying claim to the past, but again makes this claim according to present conditions. Thus history exists in the present through its claim to the past. So if the present tense is one tense (not necessarily *the* tense) proper to historical writing, as is argued here, so what? The answer to that is: some of the most important conditions of (present-based) history writing are political and ethical.

Writing history in the past tense carries the implication (or at least the possibility) that we are attempting to fix history in the past and to divorce it from the present. Given that the present is always saturated and thoroughly infused with political and ethical concerns, this

amounts to an attempt to fix (make immovable) the political concerns of the present (as expressed through the history) by rooting them in the past. We attempt to give these concerns a sure, even immutable, foundation. The discomfort of writing history in the present tense is intended to keep permanently in view the politics going on here. I do not pretend that this history is fixed, or even that it is about the past. All the things described here happened, and are documented, in the conventional sense of having happened. I am not making this up. And yet, in another way, that is precisely what I am doing. I am making this history. I am performing it, researching it, selecting it. It is a product of my political, material, social concerns. All history is like this. It is an engagement with the present, under-girded by the materials available for thinking 'the past'.

There are probably many objections to this. I shall deal with the two most obvious ones here in a rather generic way: (1) it is confusing and alienating; (2) it is inconsistent and undercuts my argument. I shall deal with the first one by simply granting it. Writing history in the present tense is initially confusing and unsettling. It is sometimes labelled 'journalistic', which is revealing, but intended to mean 'unbefitting of historical scholarship'. It is a commonplace or cliché that 'journalism is the first draft of history' and, actually, it is precisely the provisional nature of a 'draft' that I would like to preserve. This is not to say that I believe this book to be slapdash, rushed or careless. It is to say instead that I want to be clear about this book's provisional nature, that it is a story from a certain place, at a certain time, with all the practical and intellectual constraints that this entails. The unsettling nature is also something that works towards my argumentative goal: I want to make people think about the distinctions that are concealed in the use of different tenses. Whenever the narration of a 1960s event in the present tense jars, I want to provoke a little reflection: 'this is happening now, not then' in the sense that this history is being understood, disagreed with, digested, made and remade according to twenty-first-century political concerns. It is not a simple reflection of events in the 1960s. I want to be clear as well as unsettling, and I hope I can be both. In any case, some feedback I have obtained says that the initially unsettling nature of the present tense does pass, and it becomes just another story told in the present – immediate and happening now as history does.

The second objection is perhaps more serious, and certainly more specific. I am dealing with one psychological category that has delimited shelf life: 'overdosing as a cry for help'; and another that remains

very much with us in many societies: 'self-cutting as tension release'. It might be said that by talking of 'overdosing as a cry for help' in the present tense, I am implying that it is 'still here' and thus undercutting my argument about its specificity and context-dependent nature. But what does it mean to say that 'overdosing as a cry for help' is no longer with us? One could draw a comparison with nineteenth-century hysteria, characterised by catalepsies, palsies, fainting and paralysis. These behaviours, these conceptual understandings, are clearly no longer available as a widely understood pattern of behaviour. But this is to miss the point of the present tense: it is not saying that the objects described are here in the present, but that the description of them is occurring in the present. The historical descriptions of Bismarck's Germany, to take one example, are very different in 1950 to those in 1920. History is the understanding and abstracting and creating of 'a past' in the present. The present of 1950 has rather different historical concerns around Bismarck's Second Reich compared to those in 1920. My use of the present is not meant to imply that all events are happening now, but that our understanding of all events is happening now, and is always unfinished.

When I claim that history is happening now, it is also not meant in the trite sense that the past has material effects: for example, I fell over yesterday, and today my arm is broken. Instead I want to convey the sense that history – human sense-making, story-telling – is always properly thought of as happening in the present. When we forget that, we forget that human histories are always political, and always of the present. Writing in the present tense is not the only way to make this clear, but it is one way. It is not that the past (or reality) 'does not exist', or any other parodic nonsense often imputed to those ('postmodernists') who reflect critically upon the function and ethics of history. It is instead to argue that human understanding of the past is happening in the present. I want to write history with this awareness. I want to write history that is honest about its storytelling, its present function, and not confuse the mobilisation of the past with the implication of permanence and fixity. Perhaps in a different present I could write in a self-conscious, caveat-filled past tense. But today's present has the humanities under attack and the rolling back of the state's responsibilities. In addition – and most troublingly for historians – the present involves a nationalistic project under the guise of 'history as fixed facts' in schools. I cannot write in the past tense given what it implies in this present. Joan Scott argues forcefully and cogently of the value of history as critique, as work that can 'make visible the premises upon which the organising categories of our

identities … are based, and … give them a history, so placing them in time and subject to review'.[14] The present tense makes this current, political project more obvious.

Here, I can be honest about my own political commitments, and I return to them throughout. This book details a history in which the social setting, and the agencies of state that nourish and buttress it, are present to an extent that is difficult to imagine today after the triumph of a market-driven and competitive understanding of human nature. What starts as the history of a psychiatric category runs parallel to the substantial disappearance of the idea of the social setting. The argument is that the concepts with which we populate and navigate our lives are related to political concerns. Human behaviours are vast and myriad, but they stabilise and congeal in certain ways, in certain objects, at certain times. The contrast between the present of the 1950s and that of the 1980s is here deployed in the 2010s to make clear that the retreat of the social setting has political significance.

The most entrenched and reactionary politics has ready recourse to the disguise that it is 'natural' or 'not political'. As feminists keep needing to reassert, 'the personal is political', and indeed the 'psychiatric' the 'medical' the 'historical' the 'social' – it is all political. The ways in which archetypes of 'self-harm' come to prominence and fade out might seem an unlikely place for a political statement. However, it is precisely where you do not think politics is happening that it needs to be exposed. This book is about how we arrived in this present with a particular set of ideas, stereotypes – cultural and intellectual shorthand with which we make sense of (a very small part of) our world. Again, if the familiar certainties and signposts of our lives (from self-harm to neoliberal human nature) are in fact made and remade by human action, then they are up for ethical debate.

Textbook emergence

Various forms of self-harm, including 'overdosing as communication' and 'self-cutting as internal tension regulation' are not eternal, ever-present, or rooted in an unbroken undercurrent of emotional response. Therefore, the specific emergence of these different stereotypes can be introduced through analysis of successive editions of three popular British psychiatric textbooks.

The *Textbook of Psychiatry*, written by David Kennedy Henderson and Robert Dick Gillespie, becomes known simply as 'Henderson and Gillespie' over ten editions and 42 years between 1927 and 1969.

Maxwell Jones remembers Henderson as 'the great high priest of psychiatry' at Edinburgh in the early twentieth century, while Gillespie is a brilliant but ultimately tragic figure who commits suicide in 1945.[15] Willy Mayer-Gross, Elliot Slater and Martin Roth's *Clinical Psychiatry* is also a standard textbook over three editions between 1954 and 1969. It is written, according to Slater, because '[t]he textbooks available at that time were either not very comprehensive or not all that good. The American ones were mainly full of Freud, or Adolf Meyer's psychobiology. Henderson and Gillespie was rather an old-stager'.[16] The emergent phenomenon of 'attempted suicide as cry for help' can be tracked, and its underpinnings glimpsed, through the editions of these texts, written as aids for trainee psychiatrists and general practitioners, as well as reference works for specialists. In both books, the epidemic of overdosing emerges as attempted suicide is being rethought and detached from completed suicide. It is transformed from a symptom of mental disorder to an object of scrutiny in its own right. Finally, Myre Sim's *Guide to Psychiatry* is useful for tracking the emergence of self-cutting for two reasons: not only is he well-informed in the field of self-harm (having published on the psychological aspects of poisoning), but his *Guide* runs to four editions, from 1963 to 1981.[17]

In Henderson and Gillespie, the principal references to suicide and suicidal behaviour in the first five editions (1927–40) concern the need for vigilance when caring for patients diagnosed with conditions such as 'depression' or 'involutional melancholia'. Suicide appears here as one possible outcome of psychiatric illness, a potential final symptom.[18] This is reproduced throughout the five editions up until 1940, with no effort to establish any differences of intent between people who succeed in their attempts and those who fail. The preface to the 1944 edition notes that 'remarkable progress...has occurred in psychiatry in recent years', which marks 'a new epoch in medicine and emphasises what psychiatry has for so long been doing – treating the individual in his social setting and making allowance for psychological as well as physical factors'.[19] In the chapter on 'Manic-Depressive Psychoses' there is this new material: 'We have been impressed by the large proportion of cases of attempted suicide admitted to the Royal Infirmary, Edinburgh, and Guy's Hospital, London, who have never previously seemed to require psychiatric guidance or control. The rapidity with which recovery occurs is also a factor to be noted and is in striking contrast to the prolonged treatment of the average case of depression'.[20] This emergent object is tentatively cast as a new (short-term) form of depression, appearing under wartime conditions, which emphasise the social setting's relevance to treatment.

This new object is distinctive, according to Henderson and Gillespie, because of the lack of previous psychiatric contact with the patients. Indeed, naming the hospital clinics serves to clarify that these attempted suicides are first assessed at general, rather than psychiatric hospitals. They are also 'struck by the trivial nature of the precipitating factors in some cases'. For example,

> a husband requested by his wife to sleep for the time being in an attic to make room for a guest; a girl who had been 'walking-out' with a soldier of whom her father disapproved, so that being afraid to return home she walked into the Thames, near London Bridge, instead.

A supposed attempted suicide and bafflingly trivial interpersonal conflicts become visible at certain general hospitals. An element of communication is also noted in some cases, but this does not map neatly onto the division between those who survive and those who do not: 'Sometimes spite enters as a basis for the suicidal gesture, but it is a gesture which is sometimes carried to the point of successful self-destruction'.[21] These changes are linked on an intellectual level to the commitment to treat the individual in his or her social setting, which can potentially bring to light such conflicts. However, it is also down to the availability of informal psychiatric scrutiny in a clinic, outside of a mental hospital. After Gillespie's suicide, the sixth, seventh and eighth editions (1944, 1950, 1956) see radical changes in the authorship of the textbook. Henderson edits the 1950 version alone, and brings in Ivor R.C. Batchelor to assist with the 1956 edition. Despite these changes (and the fact that Batchelor publishes a number of articles on the subject between 1952 and 1955), the above text concerning 'attempted suicide' remains the same.

In the 1962 (ninth) edition, suicide and attempted suicide are clearly separated: 'Attempted suicide is much commoner than suicide in Western communities'. The idea that attempted suicide is separate from, more common, and less likely to be registered than completed suicide are key characteristics of the clinical object. Under the heading 'suicidal acts' attempted suicide is raised to the status of 'a social phenomenon of great importance and a concern not only to psychiatrists but to society as a whole'. They refer to Erwin Stengel's work on the social aspects of suicidal attempts, which leads to the suggestion that 'those who attempt and those who commit suicide constitute two different populations'. They note that Stengel's differentiation has an important gendered dimension: '[T]he majority of those who

commit suicide are males while the majority of those who attempt it are females'. However, Henderson and Batchelor are not convinced that the populations are completely separate. They allow that the populations overlap, and that it would be unwise 'to draw any sharp distinctions between attempted suicide and suicide itself.... No firm line can be drawn between suicidal gestures and suicidal attempts'. Nevertheless, they are broadly supportive of Stengel's project, arguing that 'emphasis on the appeal function of suicidal attempts and on the participation of the patient's group very properly draws attention to social aspects of individual suicidal acts'.[22]

The final (tenth) edition is published in 1969, edited by Batchelor alone after Henderson's death in 1965. Many studies of attempted suicide are mentioned; prominence is given to 'a notable increase in Britain of cases of self-poisoning, particularly with barbiturates and more recently with tranquilizing and other psychotropic drugs.... The majority of these acts are impulsive: they are often the response to a quarrel or other frustration of a temperamentally unstable or psychopathic individual'. Batchelor quotes Neil Kessel (who works at the Royal Infirmary of Edinburgh in the early 1960s but overlaps with neither author):

> Kessel (1965) stated that 'for four fifths of (these) patients the concept of attempted suicide is wide of the mark... what they were attempting was not suicide.' Certainly that there has been an attempt to seek attention and to manipulate the environment is often obvious: but Kessel goes too far in recommending that 'we should discard the specious concept of attempted suicide'.[23]

'Attempted suicide' has become a distinctive object within the field of suicidal behaviour, as a category that emphasises its potential as communicative with a social setting. Henderson and Batchelor are never quite convinced that it deserves a fully independent existence to the extent of Stengel or Kessel, but they certainly acknowledge its prominence post-1945.

The three editions of Mayer-Gross, Slater and Roth's *Clinical Psychiatry* show a similar pattern. In 1954 the authors note that '[s]*uicide*, or the attempt at it, is often the first alarming symptom of a depressive illness; it is the first and last symptom of many depressive illnesses'. They are clearly aware that there exists a less genuine class of 'attempts', affirming straight afterwards that '[i]n most cases [of depression] these attempts are desperately earnest'. The diagnoses most strongly associated with

suicide (as a symptom) are depression, schizophrenia and psychoses in the aged.[24]

In the second edition (1960) there is a new section devoted to suicide where two separate objects are visible: '[A]ttempted suicide is estimated as occurring with a frequency of four to eight times that of consummated suicidal acts'. Its distinctiveness from completed suicide is again mapped onto gender: '[A]lmost without exception the rates for men are higher than women while the reverse holds for attempted suicide'. Again, Stengel is mentioned as having 'emphasised the "appeal" character of attempted suicide, the ambiguous or "Janus-faced" attitude directed at once to the reformation of human relationships and towards death'. Once more, the textbook authors are not wholly convinced that the objects are truly discrete, arguing that 'although it would be unwise to ignore the appeal element in a suicidal attempt, it would be more dangerous to over-estimate it'.[25]

In the third edition (revised by Slater and Roth after Mayer-Gross' death in 1961), the above material now merits its own subheading of 'Attempted Suicide' in a new chapter on 'Social Psychiatry'. Slater and Roth acknowledge '[t]he point made by Stengel and Cook (1958) that these are two separate but overlapping populations is now widely accepted'. They also refer to Kessel's argument that 'attempted suicide is not a diagnosis and not even a description of the behaviour of great numbers of cases coming for treatment under this heading even when the behaviour is clearly a deliberate act of self-injury and not accidental'. They mention three studies of incidence: Kessel's in Edinburgh, Stengel's in Sheffield and Farberow's and Shneidman's in Los Angeles.[26]

Thus a clinical object named 'attempted' suicide is articulated in two standard psychiatric textbooks after seemingly being brought into focus by Erwin Stengel and associates during the 1950s. Stengel does not create this object in any simple way; even without the 'trivial' precipitants in Henderson and Gillespie (1944) and implied 'non-earnest' attempts in Mayer-Gross, Slater and Roth (1954), it must be emphasised that these ideas do not spring from nothing, yet are also significantly novel. Crucially, it is not until after *Attempted Suicide: Its Social Significance and Effects* (1958), by Stengel, Cook and Kreeger, that the textbooks take a coherent position on this phenomenon where the communicative or appeal aspect is definitively acknowledged. Similarly, psychological clinicians from the 1960s onwards speak of an epidemic of suicidal behaviour by means of overdose that they believe to be novel ('currently fashionable') in important respects,[27] and in

more recent psychological and sociological literature, the phenomenon of 'attempted suicide' is sometimes seen to begin to register around the 1960s.[28]

In both textbooks this recasting of 'attempted suicide' is based upon a shift from an action seen as a symptom or outcome of depression, to an object worthy of scrutiny more or less independently. This new object is first delineated simply by the arrival and survival of certain cases of injury presenting at general hospitals (predominantly after having taken an amount of medication). Through various interviews, investigations, follow-ups and assumptions, a social constellation is actively fabricated around the attempt, and meaning projected from the hospital into the social history of the patient. This awareness corresponds – as we have already argued – with a radical reimagining of the state's relationship with social welfare and its social responsibilities. The social setting and self-harm as social communication are brought to light (as we shall see) by particular groups – including social workers – who are part of that renewed commitment to welfare.

Overdosing becomes a serious public-health problem by the 1960s and, for a brief period, it is seemingly ubiquitous and constantly increasing at casualty departments around Britain. Then, rates begin to drop during the late 1970s, and by the early 1980s in Britain there is consistent acknowledgement of a particular sub-group of self-damaging patients. These people do not take overdoses but instead cut their wrists and forearms. It gradually becomes argued that they might be distinctive in more than just their choice of method. Increasingly, these patients are not seen as crying for help, but as regulating internal psychic tension by self-cutting. The social setting recedes, and the internal emotional life of the self-damaging patient comes into focus. This happens from the late 1970s onwards, again corresponding with a point at which the social responsibilities of the state are being rethought, with an emphasis on individual competition and self-support, rather than collective social support.

In the first edition of Myre Sim's *Guide to Psychiatry* (1963), there is a cursory mention of Stengel's and Cook's *Attempted Suicide* (1958), where he claims that 'the vast majority of those brought to the casualty department of a general hospital have what Stengel and Cook (1958) called an "appeal" character'.[29] In the second edition (1968) in a much bigger section on 'attempted suicide', Sim prefers Lennard-Jones's and Asher's 1959 term 'pseudocide' to Kessel's 'self-poisoning' because the latter 'by definition would exclude the considerable number who resort to self-wounding'.[30] Thus Sim is aware of a group of self-wounding

patients, but he does not attribute to them any motivational or psychological differences. In the 1974 edition there are significant additions in the 'attempted suicide' section, including one headed 'Wrist-scratching as a Symptom of Anhedonia'. In it, Sim paraphrases the work of Stuart S. Asch, a psychoanalytic clinician from Mount Sinai Hospital in New York, whose study is based on psychiatric inpatients. Asch's work is mentioned by Barbara Brickman and the current author as part of the group of studies at the centre of this new profile around self-cutting. Michael Simpson's comprehensive literature review of this new kind of self-cutting in 1976 includes Asch's work as one of the 'classical studies'.[31]

Sim, paraphrasing Asch, mentions a profile of young women between 14 and 21 years of age who 'complain that they feel empty or dead inside and the striking characteristic is scratching or cutting their wrists'. He also mentions eating difficulties, promiscuity and abuse of drugs as common symptoms. Sim reports that Asch believes 'the cutting is a specific technique for dealing with both the rage and the depersonalisation'. The motivation and purpose of this behaviour as a means of affect-regulation (rather than communication) is clear. Sim obviously feels that the study has some value (or else why include it at all?), but he is sceptical about this profile, adding the comment:

> Wrist-cutting is common among males, particularly in prisoners and servicemen and there must therefore be a variety of interpretations. In the present writer's experience, girls who cut their wrists are generally from social classes IV or V [the two lowest], of limited intelligence and with a delinquent history, though a few do match those described above.[32]

In the fourth edition (1981), this passage about Asch's work is reproduced, along with another comment: 'Overdosing and self-injury [are] becoming an increasingly popular form of language'. He thus has both behaviours in there, and despite his section on Asch, he runs them together – likening them to hysteria: '[I]t was well-known that conversion hysteria became epidemic when doctors treated it as a legitimate disease'.[33] By the mid-1980s, self-cutting is an established – although contested – clinical object, and the significance of the communicative overdose is soon to diminish. Having sketched briefly the careers of self-poisoning and self-cutting, we can now look, in a more general way, at the issues involved in writing a history of self-harming behaviour.

Retrospective diagnosis and source-based confusion

The idea that individuals might harm themselves consciously, and not intend to die, seems timeless. However, this timelessness is often achieved by projecting our current ideas and concepts back into the past, making past ideas and events correspond to our current understandings. This practice, known as 'retrospective diagnosis' in the history of medicine, is problematic. Because it involves using terms in approximate, supposedly 'common-sense' ways, much of the following argument, setting up against such practices, may appear unnecessarily exacting or uncharitable to the scholars analysed. However precision in terminology and analysis of the assumptions underlying the choice of a particular term, are absolutely essential throughout this book. For it is only after much effort in defining the object of one's study, and reflecting upon the nature of the sources that one is using to talk about that object, that one can argue with confidence about the object's significance. How the object is defined governs the choice of sources to which one looks to provide evidence for it. To analyse self-harm is to enter a field littered with defunct and confusing terminology, as well as with vague attempts at 'catch-all' descriptions, so precision is not simply desirable but essential.

A discussion of suicidal behaviour at the London headquarters of the Royal Society of Medicine (RSM) in December 1988, is a good example of retrospective diagnosis. Norman Kreitman and Olive Anderson both present on the topic of 'suicide and parasuicide'. At this point, Kreitman is a distinguished psychiatrist, director of the Medical Research Council's Unit for Epidemiological Psychiatry in Edinburgh, and coming to the end of a successful, if unspectacular, career in psychiatric research. Olive Anderson is a fellow of the Royal Historical Society, and her seminal book, *Suicide in Victorian and Edwardian England*, has recently been published.

Kreitman's paper on prevention strategies strongly differentiates the terms 'suicide' and 'parasuicide', claiming that they 'differ in many radical respects' and that the differences between them 'outweigh their similarities'.[34] This is unsurprising: in 1969 Kreitman and three colleagues propose the term 'parasuicide' to describe 'an event in which the patient simulates or mimics suicide'.[35] As seen above, psychiatrist Erwin Stengel is credited by many with founding this new kind of concern around attempted suicide.[36] He sets himself up explicitly against the notion that 'a person who has attempted suicide ... has bungled his suicide'.[37] Kreitman's terminological offering of parasuicide

is one of many interventions reinforcing and rearticulating a distinction between acts aimed at causing death and those motivated by a more complicated and ambiguous intent. However, he is doing it in a specific context: his research from the late 1960s onwards focuses almost exclusively upon individuals conveyed to hospital after an overdose of medication.

Anderson's paper provides an historical gloss on suicide in Western Europe, from the late medieval period to Edwardian Britain. Perhaps prompted by Kreitman's presence, she includes a section on Victorians and parasuicide. This interdisciplinary attempt to communicate with clinicians on their terms – and at the RSM no less – is laudable. However the way in which she deploys the concept of parasuicide in an historical paper exposes the problematic relationship that sometimes obtains between history and psychiatry (and this despite her wider, careful and critical scepticism around labelling and suicidal behaviour). Her contribution here claims: 'Parasuicide is necessarily parasitic on a widely diffused assumption that self-harming behaviour should be responded to with help, sympathy and remorse, and this cultural breeding-ground flourished in Victorian England'.[38] It is important to be clear on what Anderson is doing here. She is making sense of the behaviour of people in Victorian and Edwardian Britain by using a term fashioned in a 1960s debate over communicative overdoses of medication.

Projecting parasuicide into the past in this way makes the behaviour (as defined by the 1960s terminology) seem timeless, ever-present and unchanging. The historical meaning of human action is flattened into current terminology, a description that is unavailable in Victorian Britain. In order for this analysis to work, the notion of a 'widely diffused assumption' stretches between the late 1980s and the Victorian era. In other words, the behaviour's meaning is cast as intended to procure 'help, sympathy and remorse' whether performed at the end of the nineteenth or the end of the twentieth century. This is a projection of the social setting – which is bound up with the core meaning of 'parasuicide' as well as a particular political period – into the past. The actions described by this term in one period are projected into the past. Assumptions and exclusions that create and isolate a stereotypical pattern of behaviour (its purpose, possible diagnoses and prognoses, the method employed, the gender, class or age profile, etc.) are transported from one context and imposed upon another.

Though Anderson seemingly makes parasuicide fit, the problems inherent in abstracting the term and projecting it into the past endure. She describes a nineteenth-century process in which the objective in

assessing supposedly self-destructive behaviour is to 'distinguish the sham from the real', which is 'a daunting responsibility'.[39] This has superficial resonance with Kreitman's concerns, as when parasuicide is proposed it is claimed that 'what is required is a term for an event in which the patient simulates or mimics suicide'. However, parasuicide does not really speak to a debate between sham and real. The term differentiates between a largely uncomplicated wish to die and something much more complex than mere fakery: '[R]arely can his behaviour be construed in any simple sense as oriented primarily towards death ... this act, which is like suicide yet is something other than suicide'.[40] All this is lost in the redescription.[41]

The projection of current terms back into history leads to a second problem concerning historical sources. The set of historical phenomena (behaviours) understood through the parasuicide label are accessible because they are recorded and scrutinised in a particular Victorian context; these sources bear scant relation to those that underpin the 'parasuicide' term. This leads to a lack of awareness of the differences between the sources used to speak about suicidal behaviour – differences that have consequences for the historical objects described. One of the key sources supporting Anderson's claim that 'recorded suicide attempts far outnumbered registered suicides in Victorian London' is a one-off: 'Numerical Analysis of the Patients Treated in Guy's Hospital' (a general hospital) between 1854 and 1861. Information on 'attempted suicide' also comes from various police reports, as suicide is illegal in England and Wales until 1961 (see Chapter 3).[42] A term produced in the mid-twentieth-century around communicative overdoses brought to National Health Service (NHS) hospitals is unsuitable for understanding an attempted suicide composed of police records and a one-off hospital analysis. Combining information collected in different ways and for different reasons – and according to different definitions – to make a single object of concern termed parasuicide (under a different definition again) constitutes another problematic neglect of context.

Anderson is far from alone in making these leaps and is by no means the worst offender, but her interdisciplinary overstretch is a neat example that falls some way short of the thorough, nuanced work in her book. Projections like these make sense of a wide range of behaviours by rooting them in some eternal (and often unstated) emotional response or 'distress' or in a 'widely diffused assumption'. The history practised here aims to place understandings of behaviour in historical context, whether at the zenith of the welfare state or the ascendancy of

neo-liberalism. It aims to show how practical arrangements and specific intellectual assumptions generate meaning in context. The past is to a great extent always a projection of present concerns, but this does not necessitate collapsing the past into present meanings.

These meanings are even more important when considering psychological categories that ascribe meaning to the actions of human beings who, themselves, are aware that they are being described and labelled in various ways. Through interaction with these powerful diagnostic labels, people can come to understand themselves through the motivations and emotions provided by the diagnoses. Telling someone that they are 'unconsciously crying for help' when they profess to be trying to kill themselves can change how individuals understand their own actions. Diagnoses can become much more than labels – they can form part of people's identities. If such descriptions are unavailable in a certain context, and the labels are different, the meanings produced are different.

After engaging briefly with some current accounts of self-harm, we can open up these conceptual and philosophical issues about descriptions of behaviour in the past, asking precisely what we mean by an epidemic of communicative overdosing before asking how it becomes available to historians in credible ways. The various sources of information (coroners' statistics, police reports, hospital records, etc.) that allow historians to access 'suicidal behaviour' are assessed, and the consequences that flow from using different kinds of information are outlined. These differences are a crucial part of the context. Since the nineteenth century, studies of suicide have been largely based upon well-established judicial registration procedures (coroners' statistics) from which a picture of 'suicide' is formed. No such registration practices exist for 'attempted suicide' in this period. From the late 1930s this phenomenon of overdosing emerges from hospitals, which are very different indeed from coroners' offices. The easy combination of material from very different sources (highlighted in Anderson's combination of hospital and police records to produce parasuicide) also occurs in the literature between coroners and hospitals, between suicide and attempted suicide. The distinction between two sources of information is erased.

We then turn to the specifics of our story. The context right at the core of this work is one which enables patients who arrive at hospitals after having suffered a physical injury to be assessed by psychological and psychiatric clinicians. It is this psychological expertise, and the assumptions contained within it, that enable the presenting physical injury (in

this period, an overdose of medication) to be transformed into a pathological communication, a symptom of a disordered social environment, a simulation, or a cry for help. The possibilities for patients arriving at general hospitals to get consistent psychiatric assessment expand rapidly between 1950 and 1970. From the middle of the nineteenth century, much of British psychiatric practice is focussed upon the relatively remote mental asylums. The Mental Health Act 1959 is a familiar landmark in twentieth-century psychiatric history, representing a shift from this segregated model of provision. However, its impact in removing all legal obstacles for psychiatric treatment at general hospitals (where most attempted suicides are taken in the first instance, if at all) has been obscured by the dominant story of the failures of community care for the mentally ill coming out of psychiatric hospitals. In other words, the growing possibility of getting psychiatric treatment at a general hospital (which is not the community or an asylum) is absolutely crucial in the rise of this psychological object to national prominence.

The final section focuses upon the specifics of this psychiatric assessment. The place of the social environment and social relationships in mid-twentieth-century psychiatric thought (and especially psychiatric epidemiology) is of paramount importance in Britain. Thus, historically specific types of psychological expertise recast physical injury as a symptom of pathological social settings and relationships. Communicative self-harm emerges from a psychiatric tradition that focuses upon the social environment and psychiatric illness as communication. The idea of a cry for help might well have a broad intellectual ancestry, but it is structured and articulated by much more immediate intellectual and practical concerns.

Projections into the past: history and epidemic overdosing

Literature that engages historically or sociologically with the specific twentieth-century overdose epidemic is rare. The predominant approach presumes, explicitly or implicitly, an ahistorical constant which animates the so-called distress behaviour across time. Anderson's imposition of 'parasuicide' is especially clear in the second decade of the twenty-first century. The term never achieves sufficient popularity to be widely understood by non-medical audiences. As noted, the stereotype associated with it – the communicative overdose – has been largely forced from view by competing understandings of behaviour under the labels 'self-injury', 'self-harm' or 'self-mutilation'. As outlined above, from the 1980s onwards, the stereotype for intentionally self-harmful

behaviour that is not directed at ending one's life involves young people cutting their forearms with sharp objects in order to regulate internal psychic tension. The overdose becomes recast as a genuine attempt to end life.

Digby Tantam and Nick Huband open their 2009 text with one of the clearest statements of differentiation between self-injury and self-poisoning, disqualifying themselves from commentary on the latter:

> This book focuses on people who repeatedly injure themselves by cutting, burning, or otherwise damaging their skin and its underlying tissue. This 'self-injury' is one of the two main types of self-harm, the other being self-poisoning with household or agricultural chemicals, or with medication.... Self-injury and self-poisoning are often regarded as sufficiently similar to be considered as two facets of one problem. This fits with the observation that many of those who cut themselves also take overdoses, but it is not consistent with the very different cultural and psychological roots of self-injury and of self-poisoning.[43]

Making a related point, Jan Sutton, another twenty-first century expert on deliberate self-harm (DSH), uses questions-and-answers to analyse the term 'self-inflicted injuries'. This term is used generically in the media (and in Sutton's view, misleadingly) to talk about statistics from studies that include both cutting and overdosing: 'What sort of image does that [term] conjure up? Overdosing? I doubt it. Cutting? Highly probable'. She explicitly, and with confidence, closes 'self-injury' down into one specific behaviour: 'mention the word "self-harm" and it immediately conjures up images of people cutting themselves'.[44]

As well as this difference in the archetypal behaviour of self-harm, the dominant motivation from the 1980s onwards is seen to be the relief of internal tension.[45] In this way, as far back as 1978 Keith Hawton distinguishes between the motivations of self-cutters and self-poisoners (see Chapter 5).[46] Ideas of communication with a social circle or crying out for help become bound up in negative stereotypes about 'attention-seeking' behaviour, which is seen as unhelpful by many experts on self-harm. In Britain in 2004 and 2006 controversies erupt over self-harm where such negative stereotypes appear in national newspapers.[47]

In tune with Anderson's analysis, many experts argue that current self-injury concerns, the parasuicide epidemic of the 1960s and 1970s and Victorian attempted suicide are indeed largely the same thing and form an unbroken chain back into the past. Armando Favazza argues that

self-mutilation has existed as long as humans have existed, finding it in 'Tibetan Tantric Meditation, North American Plains Indian mysticism and the iconography of Christ's Passion'.[48] Sutton claims that '[d]eliberate self-harm, parasuicide and attempted suicide [–] essentially they all refer to the same behaviour, and are sometimes used interchangeably'.[49] In the 1960s, eminent toxicologist Sir Derrick Melville Dunlop performs a similar projection using notions of hysteria:

> [D]ifferent generations tend in certain respects to vary in their patterns of behaviour. Thus, in Victorian times and in the earlier part of this century, in order to escape from a situation which had become intolerable, it was common, especially for younger women, to develop 'the vapours' – crude hysterias, fits, palsies, catalepsies and so forth. These hysterical manifestations are rare nowadays: it is easier to take a handful of tablets ... not usually with any true suicidal motive but rather just to seek oblivion from, or to call attention to, unhappiness.[50]

Such a narrative involves a vision of the Victorian period different to Anderson's. However, the presumption of a pattern that only varies on the surface, if at all, is common to both methods of unifying the present and the past. They both use the past to anchor currently valid methods of sense-making.

That a relatively durable meaning might be stubbornly projected into many diverse behaviours – from catalepsies and fits to taking a handful of tablets – does not make it somehow eternal. That self-harm might 'seem to recur predictably' – to borrow from Joan Scott – does not insulate it from history, as not only are the 'specific meanings ... conveyed through new combinations', but the very assumption of sameness needs to be investigated.[51] This kind of analysis equates current concepts (and their contextual baggage) to past phenomena produced in very different ways, for different purposes, through different practices, and understood through different assumptions. This conceptual 'presentism' cannot deal adequately with historical change. It must assume something real – that is, constant – underneath the different terms in different contexts.

How did self-harm become an object of study, and what kind of object is it?

Given these problems, how are we to proceed? Reversing Ruth Leys's formulation, borrowed for this section's heading, the first questions to

be asked are: What precisely do we mean by saying that self-harm or parasuicide happened in the past? What kind of object is a communicative overdose in the past?[52] Having answered these questions, we can then discuss the implications of practising history in these ways. Finally, we can see how self-harm comes to be an object of study – that is, how it is recorded and treated as a statistical or clinical concern. This helps to explain how a specific epidemic of communicative overdosing becomes possible, prompting important questions about how and why human beings might behave in certain ways and at certain times.

In order to achieve a working definition of what self-harm is, it is useful briefly to revisit a debate initiated over a decade ago around chapter 17 of Ian Hacking's book, *Rewriting the Soul*, entitled 'An Indeterminacy in the Past'.[53] This debate focuses on whether a re-description of actions in the past using present categories (such as Anderson's use of parasuicide to describe actions in Victorian Britain) is legitimate, and whether it changes the actions. Hacking's questioning examples include: Are Canadian soldiers shot for desertion during the First World War, now sufferers from post-traumatic stress disorder (PTSD)? Is an eighteenth-century, 48-year-old Scottish explorer a child molester (then or now) for marrying a 14-year-old girl?

The legitimacy and consequences of various re-descriptions are analysed through Hacking's engagement with influential Wittgensteinian philosopher G.E.M. Anscombe's *Intention* (1957). In Anscombe's argument, the most relevant point to Hacking's project (and what emerges in the debate) is the focus upon context. Hacking engages with Anscombe's key example of a man pumping water. He states that

> [o]ne of the ways in which human action falls under descriptions is in terms of the way the action fits into a larger scene. The man's hand on the pump is going up and down. Enlarge the scene. He is pumping water. Enlarge the scene. He is poisoning men in the villa. As Anscombe makes so plain, the intentionality of an action is not a private mental event added on to what is done, but is the doing in context.[54]

Kevin McMillan's contribution to the debate makes this contextual point especially clear. He argues that we can get a handle on what social phenomena might be (for example, an epidemic of attempted suicide) by 'identifying and distinguishing them in terms of their historical, cultural or domain specificity'. He appreciates that this has consequences: 'An emphasis on specificity may make us chary of indiscriminate retroactive

re-description. When applied, re-descriptions – particularly in terms of modern moral concepts – drag a complex and extensive practical, moral, epistemic and conceptual baggage in tow'.[55] It is an appreciation of this baggage that is crucial to understanding self-cutting, overdosing, and so on, in a fully historical way – to be wary of describing past actions with current concepts, or of collapsing them into one another.

Following this line of analysis means that socially directed attempted suicide cannot exist as a concept or pattern of behaviour independent of the institutional channels and professional scrutiny through which it is constituted. Specifically, this involves the increasingly consistent provision of psychiatric scrutiny available to patients presenting at general hospitals (as we shall see below). To separate the communicative self-harm from these practices would be to divorce it from its context. Following Allan Young's argument around the category of post-traumatic stress disorder (PTSD), it is argued here that self-harm 'is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions and moral arguments that mobilized these efforts and resources'.[56] Particular practices and technologies (new arrangements for psychological scrutiny) create attempted suicide as cry for help. As the contexts change, the objects change. This is not to say that people in the past have not used the terms 'cry for help' or 'attempted suicide' or that they were wrong to do so. However, they are not talking about, recording or accessing the same thing.

It is negligent to collapse this diverse richness into the psychological (or neurobiological or sociological) categories that happen to be current today. Adrian Wilson argues that 'concepts-of-disease, like all concepts, are human and social products which have changed and developed historically, and which thus form the proper business of the historian'. He describes the consequences of retroactive re-description, an approach

> in which diseases throughout history have been identified with their modern names-and-concepts ... the effect of this approach is to construct a conceptual space in which the historicity of all disease-concepts, whether past or present, has been obliterated. Past concepts of disease have simply been written out of existence; and the historicity of modern disease-concepts (or what are taken to be modern ones) is effaced, because those concepts have been assigned a transhistorical validity.[57]

This effort to homogenise and assimilate might well have a present utility, as well as broadly progressive political effects, as in the case of Canadian deserters and PTSD. However, in order for objects to have such a transhistorical and decontextualised existence, their conditions of production must be obscured; in other words, they only make sense outside of context – utterly unhistorical. Thus the meaning of an epidemic of communicative attempted suicide is more precisely stated: a specific understanding of behaviour, inseparable from its context. Having established the importance of context in general, the specifics can now be tackled.

This object emerges from of a complication of behaviour previously thought to be suicidal. Behaviour that presents at hospital ostensibly as an attempt to inflict death upon oneself is recast as a communication, as an appeal to a social setting. To understand how this attempted suicide comes to be a clinical, statistical and an epidemiological object, we must compare the historical and institutional contexts through which self-harm and completed suicide are accessed and analysed in Britain in the nineteenth and twentieth centuries. Mid-twentieth-century suicide strongly resembles its nineteenth-century counterpart as it is accessed through coroners' court records. However, objects called attempted suicide in the nineteenth and twentieth centuries (including communicative overdoses in the latter period) are separated by a profound difference, with far-reaching consequences.

Attempted suicide in the nineteenth century: asylums, and others

Information about attempted suicide in the nineteenth century comes from a variety of sources. Anne Shepherd and David Wright use the most popular set of source materials used to access these 'suicide attempts', county asylum records. They argue that these provide 'a useful comparison to the more frequently used coroners' reports that underpin most research on Victorian suicide'. They describe

> a dominant and influential tradition of researching the history of self-murder from death certificates, coroners' reports, and official parliamentary statistics. We thus know a great deal about those who were 'successful', but much less about those who had 'failed' to take their own lives. Attempted self-murder remains relatively uncharted territory.[58]

Shepherd and Wright do not elaborate upon the differences between the various registration practices, nor on the consequences flowing from the different kinds of access to 'failed' or 'successful' objects in the past. However, they do suggest that the label 'suicidal' includes both 'real' and 'fake' attempts, and is therefore ambiguous.[59]

Åsa Jansson's conceptually precise study of suicidal propensities in nineteenth-century psychiatric literature and asylum casebooks demonstrates the fundamental relationship between recording practices and conceptual possibilities, concluding that there is no easy relationship between the adjective suicidal and the noun suicide in this period. This position is based upon a clear and consistent appreciation of the different recording and statistical practices that underpin them. The former ('suicidal') is based upon asylum statistics, the latter ('suicide') on coroner's statistics. These are collected in different ways, under different definitions, for different purposes.[60] Sarah Chaney's study of suicide at Bethlem (1845–75) is thorough and detailed, including sustained efforts to access and analyse meanings around attempted suicide.[61] Both show that nineteenth-century (and before) information about attempted suicide does not come from so organised and systematic a source as coroners, who record and categorise the dead, not the living attempter.

Twentieth century: observation wards and general hospitals

Erwin Stengel, influential commentator on communicative self-harm, does not use asylum statistics for his studies in the 1950s and 1960s. He begins his most influential researches through clinical work in mental-observation wards attached to general hospitals, places significantly associated with attempted suicide patients. These are parts of general hospitals where psychiatric scrutiny is available. This crossover point between general and psychiatric medicine, along with the inclusion of mental health services in the NHS, forms an absolutely crucial historical context for the emergence of this epidemic of overdosing. This object, named (somewhat misleadingly) 'attempted suicide' by Stengel, begins to grow. It is based upon the psychiatric scrutiny and assessment of patients brought to general hospitals after having suffered an injury presumed as self-inflicted (the majority of which are overdoses), principally at these mental-observation wards. It is increasingly recast as a pathological communication with a social circle or significant other. A number of psychiatrists, including Frederick Hopkins in Liverpool (1937–43), Stengel in London (1952–8) and Ivor Batchelor in Edinburgh

(1953–5) begin to exploit the uneasy cohabitation of general medical and psychiatric expertise in these 'secure' areas connected to various general hospitals.

Suicide statistics from coroners' court proceedings are thus fundamentally different to psychological analyses of attempted suicide from mental-observation wards. Despite this difference, it is still possible to connect suicide and attempted suicide in an abstract sense, at a level of competence: individuals wishing to kill themselves might survive by accident, or someone attempting to cry for help might die after causing an injury more serious than intended. Nevertheless, the data through which these objects are constituted – through which historians are able to study them – are not the same.

Hopkins and Stengel are aware of some differences. Hopkins, whose study forms part of Chapter 1, mentions in 1937 that there is 'no one authority to whom all [attempted suicide] cases must be notified'.[62] Stengel, combining observation ward records with extensive interviewing, laments in 1959 that 'there is no machinery for their registration'.[63] They both implicitly contrast observation wards with coroners' courts, and the laws that require suicide deaths, but not attempts, to be registered. However, this contrast primarily establishes the inadequacy of the former, rather than their fundamental difference. Later, during the 1970s, the context for self-harm shifts again: from general hospital A&E departments to psychiatric inpatient facilities. Again, the data available at these institutions are significantly different.

The work of Michel Foucault provides strategies for analysing the changing, historically specific technologies that produce 'objective facts' about the world. He claims that through analysis of these technologies, these practices, it 'can be seen both what was constituted as real for those who sought to think it and manage it and the way in which the latter constituted themselves as subjects capable of knowing, analyzing, and ultimately altering reality'.[64] The present book undertakes close analysis of specific practices and contexts to show how ideas of self-harm could function, for a time, in certain places, as an idea, a diagnosis, an epidemic. It also shows how ideas might change and correspond to broader political shifts around welfare provision, social work and the later rise of neo-liberal individualism. There is no attempt here to find the 'real' meaning or some unchanging emotional response that is expressed through varying cultures, but to appreciate the fundamentally historical character of concepts.

Having argued for the centrality of context, it is important to sketch out two specific contexts being drawn in increasing detail throughout.

General medicine and psychiatric expertise are persistently separate throughout this period, but the ways in which these approaches are separated undergoes radical change. The second context concerns social psychiatry. This particular conception of mental disorder, and the importance of social relationships in the aetiology of psychic disturbances, are vital parts of the credibility of an epidemic of communicative overdosing. A huge amount of intellectual and practical labour is invested in accessing the 'social settings' of people brought under psychiatric scrutiny. This is the same social setting with which the 'attempted suicide' is said to be communicating, and part of the social that falls away in the 1980s when 'self-cutting as tension reduction' begins to displace 'overdose as cry for help' as the archetype for self-damaging behaviour.

Separated therapeutic approaches

According to standard narratives mental medicine is largely separate from other branches through the geographically remote lunatic asylum from mid-nineteenth century Britain.[65] This insulation of psychiatric from general medicine is a key area in which change is sought during the twentieth century. A divide endures: the *National Service Framework for Mental Health* (1999) recommends that mental healthcare be provided by 'single-speciality mental health trusts' in urbanised areas, proposing a sharp administrative division between psychological and general medicine. Two liaison (general hospital) psychiatrists argue in 2003 that 'these mental health trusts threaten to repeat the mistakes of their 19th-century predecessors' by perpetuating the stigma of mental illness, and undermining the view that 'the distinction between physical and mental illness is conceptually flawed'.[66] Regardless, single-speciality trusts are again championed in a 2007 Department of Health Annual Report.[67] The mid-twentieth-century history of this divide runs through three acts of Parliament: The Mental Treatment Act 1930 allows non-certified treatment in county asylums; the establishment of the NHS (1948) brings mental and general medicine under the same administrative structure; the Mental Health Act 1959 removes all legal barriers to the treatment of mental illness in general hospitals. These developments are written into a smooth narrative of progressive integration, with 1959 as the culmination of the process.[68]

This simplistic narrative flattens the three decades between 1930 and 1960 into a smooth road away from legal constraint and the stigma of separation, and from asylums themselves in a process known as deinstitutionalisation.[69] Efforts to integrate the separated therapeutics of mental

and general medicine form a crucial backdrop throughout this book, but instead of being smooth or teleological, this process is uneven, faltering and local. This separation of mental from general medicine is not inevitable, or rooted in some deep-seated consistent organising principle. It is the result of a number of complicated historical developments, and is sustained by specific practical and institutional arrangements.

Psychological scrutiny becomes entrenched in general hospitals, and the crossover between physical and psychological medicine forms the core of attempted suicide throughout the period. The shifting and specific arrangements that effect this crossover are described sequentially. It is worth reiterating here that these divisions are not self-evident, natural or inevitable; this will become clear as each arrangement is discussed in turn. This argumentative focus cuts across the standard asylum-to-community narratives in the history of twentieth-century psychiatry. Too close a focus on the well-tilled ground of 1959 obscures the significance of developments in general hospital mental-observation wards that significantly foreshadow the late 1950s attempts to combine psychological and general medical expertise.

During the early 1960s, studies emerge from various places (including London, Edinburgh, Birmingham and Sheffield) establishing attempted suicide as an epidemic phenomenon. This is principally because the opportunities for psychological scrutiny of patients presenting at hospitals with 'physical injuries' is increased by the changes and trends made explicit and further enabled in the Mental Health Act. Attempted suicide becomes an object of study through a transformation of physical injury into a psychosocial disturbance. That is, the injury that provokes admission to hospital is subordinated to a pathological social situation or psychological state. Patients arrive at hospital casualty departments, the most non-specialised part of the hospital system, due to a physical injury. After this has been assessed for its urgency, the patient might be treated with stitches or stomach-washing within the department, or transferred for resuscitation or surgery. It is only after this physical injury has been dealt with that the patient is investigated from a social-psychiatric point of view, and this is increasingly carried out by different medical professionals. Patients must consistently be referred for psychological scrutiny if the supposed cry for help is to emerge on any significant scale. This transformation thus rests upon two innovations: consistently applied arrangements focussing psychological scrutiny upon patients presenting with a physical injury at a general hospital, and the resources for intense scrutiny and social follow-up, to fabricate a credible social setting to which the attempted suicide is

supposed to be appealing. (The strong differentiation between physical and psychological used to clarify this transformation might be unclear, unimportant or ambivalent for the patients, or anyone else who helps effect their removal to a hospital.)

Relating a physical injury to a social, domestic, romantic or familial context is time-consuming and labour-intensive, requiring interviews, questionnaires, social workers, follow-up and home visiting. The injury is not just contextualised, it is fundamentally recast as a symptom of this social setting. A specifically domestic social context is constructed in various credible ways by a newly influential profession of psychiatric social workers (PSWs). It is through consistent psychological scrutiny around general hospitals that suicidal intent is made complex and ambiguous, in a consistent and stable way. The possibility for this epidemic is, therefore, fundamentally contextual and historical. It is constituted and sustained by various possibilities for different kinds of scrutiny within a specific healthcare system. Changes in hospital organisation, mental healthcare provision, medical research and the law are all implicated in the emergence of this new object.

Stress, social psychiatry and psychiatric epidemiology

Just as the administrative separation of (and referral between) general and psychiatric medicine is important in the constitution of communicative attempted suicide, the type of psychiatric scrutiny focused upon the cases so referred is also important. This psychological object emerges through psychiatric epidemiology. This branch of psychiatry associates mental disorder with certain features of the environment – in this case, the social environment. There is a thriving field analysing the history of this psychiatric sub-specialism.[70] It is significant (and unsurprising) that a branch of mental medicine so concerned with social spaces and relationships interprets self-inflicted injuries as communications with that social environment. (It is important not to confuse the specialised, environment-focused usage of 'epidemiology' with the common usage of 'epidemic', meaning simply a high number of people affected.)

Ideas of stress and coping are integral to social psychiatry and psychiatric epidemiology in Britain. Mental disorder is embedded in social relationships and situations through notions of 'stress'. Mark Jackson's survey of twentieth-century stress research 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'.[71] The history of psychology traces

'stress' back through the work of Hans Selye (1907–82), whose General Adaptation Syndrome is based upon endocrinological experiments with mice; and Walter Canon (1871–1945), whose first famous experiments are with dogs (he later coins the phrase 'fight or flight' to describe responses to stress and establishes the concept of 'homeostasis').[72] This leads back to Adolf Meyer and his use of a 'life chart' to explain psychological disorder. Jackson cites the influential works of Harold Wolff, Daniel Funkenstein, Roy Grinker and John Spiegel as evidence that it is this psychosocial approach 'rather than Selye's experimental physiology that came to dominate clinical and epidemiological accounts of stress'.[73]

Stress gains prominence during the late 1960s and 1970s through psychological rating scales, especially the US-based work of personality theorist Raymond B. Cattell, and Thomas Holmes and Richard Rahe's Social Readjustment Scale and Schedule of Recent Experience (1967). In Britain, anthropologist George Brown and social psychiatrist Tirril Harris construct the Bedford College Life Events and Difficulties Scale in the 1970s.[74] Perhaps the most influential twentieth-century articulation of stress is found in Post-Traumatic Stress Disorder (PTSD), the genesis of which Allan Young meticulously charts through Veterans' Administration hospitals in the aftermath of the American war in Vietnam.[75] Rhodri Hayward argues that it is 'now a commonplace among psychiatrists, sociologists and historians to bemoan the ill-defined nature of stress and the theoretical fecundity that this sustains'.[76] Precisely this fecundity is the focus here, for stress is much broader than this particular historical thread. It is a key intellectual plank for the projects of social psychiatry and psychiatric epidemiology, through the links it makes possible between environment and mental disorder.

The necessity for a new model to guarantee 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. After 1945, epidemiological methods are increasingly applied in psychology. Mark Parascandola argues that 'by the 1950s epidemiologic methods and thinking had expanded beyond the mere study of epidemics to human experiments testing preventative interventions, case-control observations in hospital patients, and the long-term study of generally healthy cohorts'.[77] The 'epidemiology of mental disorders' begins to make sense – as the distribution of mental problems within a defined area. However, this shift is controversial for some. In 1952, a professor of Bacteriology writes in 1952 of his fury 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[;] ... an epidemic is disease prevalent among a people or a community at a special time, and produced by some special causes not generally present in the affected locality. Therefore, 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.[78]

Michael Shepherd – the first ever professor of Epidemiological Psychiatry – points out that this is not a new concern. He cites J.C.F. Hecker's *The Epidemics of the Middle Ages* (1859) which, in addition to surveying the Black Death and the Sweating Sickness, also deals with an epidemic of 'disordered behaviour, the Dancing Mania [and] makes no distinction between epidemics of infectious disease and those of morbid behaviour'.[79] However, psychiatrist and anthropologist 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, specialised 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'.[80]

Carstairs glosses the history of psychiatric epidemiology in his application to head this research unit. Two key events are the 1949 annual conference of the Milbank Memorial Fund in New York and a review by Eric Strömgren from 1950. Carstairs also mentions a London-based 'international working party on research method in psychiatric epidemiology' in September 1958, which met to 'discuss, amend, and finally endorse a "canon" of research methodology', which is later published under the auspices of the World Health Organization.[81] Despite this, there remain serious conceptual issues with psychiatric epidemiology – namely the lack of a single agreed model to relate mental disorder to groups of human beings, rather than individuals.

Psychiatric epidemiology and social psychiatry begin to make sense in the twentieth century thanks to a broad and eclectic set of explanations under the terms 'stress' and 'distress', which are neither normal nor pathological. In the twentieth century, 'the social' is rearticulated

through 'stress', 'distress' and 'coping' in new and pervasive ways as a source and broad canvas for psychological problems, so that by the early 1950s 'the psychiatrist... is incessantly forced to consider the social relations of his patient'.[82] David Armstrong's *The Political Anatomy of the Body* (1983) contains perhaps the most compelling and wide-ranging demonstration of this in a British context. Armstrong's argument is structured by a shift from 'panoptic' to 'dispensary' medicine:

> the panoptic vision created individual bodies by objectifying them through their analysis and description[.] ... The new body is not a disciplined object constituted by a medical gaze which traverses it, but a body fabricated by a gaze which surrounds it[,] ... a body constituted by its social relationships and relative mental functioning.[83]

Further, the link between social relationships and stress is made clear by Armstrong through links with sociology: 'In 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. ... In short, sociology has reinforced the shift of the psychiatric gaze'.[84] In 1965 Neil Kessel expresses 'self poisoning' in the language of limits and 'coping': 'Nobody takes poison, a little or a lot, to live or to die, unless at that moment he is distressed beyond what he can bear'.[85] The idea that communication is central to mental illness is broadly characteristic of psychiatric thought after the Second World War. It is no coincidence that it emerges in the context of the state's efforts to manage the social setting, through social work and socialised medicine. In a context wherein collective responsibility for health and social security is established, this idea of health and disease as socially embedded and communicative is widespread. In fact, this idea becomes central to so-called 'anti-psychiatry' as much as mainstream psychiatric thought.[86]

In Jurgen Ruesch and Gregory Bateson's *Communication: The Social Matrix of Psychiatry* (1951), Ruesch touches upon the practical shifts mentioned above, noting that '[p]sychiatrists 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'. Importantly, this leads to the argument that 'it is necessary to see the individual in the context of his social situation'. In fact he goes even further, claiming that it is 'the task of psychiatry to help those who have failed to experience successful communication'

and that '[p]sychopathology is defined in terms of disturbances of communication'. Ruesch admits that such a formulation might be a little surprising, but that the sceptical reader need only open a text-book of psychiatry to find that terms such as 'illusions', 'delusions', 'dissociation' or 'withdrawal' in fact 'refer specifically to disturbances of communication'.[87]

A decade later, Thomas Szasz's *The Myth of Mental Illness* (1961) casts hysteria as an archetype for psychiatric practice, an 'historical paradigm of the sorts of phenomena to which the term "mental illness" refers'. In other words, hysteria is not only an excellent example, but the definitive example. One of the pivotal chapters in this foundational text of anti-psychiatry is 'Hysteria as Communication'. Similar to Olive Anderson's comments about distinguishing sham from real in Victorian attempted suicide, Szasz argues that hysteria 'presents the physician with the task to distinguishing the "real" or genuine from the "unreal" or false'.[88] This also links up to Derrick Dunlop's (1967) and Raymond Jack's (1992) associations of self-poisoning with hysteria. Ideas around communication are absolutely central to psychiatric thought during the post-war period, even whilst they are anchored in, and stabilised by, much older concerns.

The emergence of social psychiatry, undergirded by the analytical tools of coping and stress, casts mental illness as a form of communication: attempted suicide as cry for help is an expression of, and a driving force behind, this turn to the social. The method here is to chart the rise and fall – between the late 1930s and early 1980s in Britain – of a particular set of techniques and institutional practices used to constitute and manage shifting forms of self-damaging behaviour. This does not presume an unproblematic or common-sense existence for these phenomena, but details the specific conditions in which meaning is produced. Overdosing as a cry for help is founded upon two principal innovations: institutional arrangements that focus consistent psychological scrutiny upon people presenting at general hospitals primarily for 'physical' injuries, and interventions that access and bring to relevance a credible 'social constellation' around the 'attempt'. This is predominantly based upon the evidence provided by psychiatric social workers; social work in general is central to the state's commitment to the management of social life. Self-cutting as tension regulation emerges first in inpatient populations, and is then projected onto different groups of people presenting at A&E. This focus on internal, individual tension reduction grows influential in a political context in which neo-liberalism

stresses the virtues of individual self-reliance over collective provision. These are not simply strategies of interpretation or emphasis that enable a pre-existing overdose or self-cutting incident to become more visible or coherent. Practical and institutional arrangements and politically resonant sense-making produce this object in a fundamental sense. We shall see how, when and where this clinical and epidemiological object emerges and is consolidated into an increasingly common and explicable phenomenon.

Chapter 1 looks at an object under the name 'attempted suicide' prominent during the early twentieth century (1910s and 1920s). This is compared to one found in the late 1930s, in a mental-observation ward attached to a general hospital. This 1937 study marks the emergence of a distinctive psychological, psychosocial object. Chapter 2 assesses the significance of the Second World War (1939–45) and the subsequent founding of the NHS (1948) for this psychological concern, and subjects some of the work of Ivor Batchelor (1953–6) and Erwin Stengel (1952–8) to close reading, both in terms of their intellectual contents and institutional settings. Chapter 3 takes a close look at the Mental Health Act (1959) and the Suicide Act (1961), to see how various legal changes enable much broader governmental intervention focusing psychiatric attention upon physically injured patients, enabling the object to assume national (even 'epidemic') significance. Chapter 4 examines a government research unit on psychiatric epidemiology in Edinburgh, and on how the profession of psychiatric social work is vital in relating a hospital attendance to a social situation, calling the object 'self-poisoning'. Chapter 5 details the rise of a new form of 'self-harm' in Britain – self-cutting as a means of internal tension reduction – which surfaces during the 1960s (in both Britain and North America). The British literature on self-cutting is analysed, with the chief focus on how self-cutting emerges in inpatient settings and is gradually understood as motivated by internal tension, rather than analysed as a potentially contagious social phenomenon. This internal tension is then seen to differentiate self-cutting from self-poisoning; self-cutters are previously a barely remarked-upon minority in parasuicide studies at A&E departments. Self-poisoning then falls out of the spotlight somewhat, as the new behavioural phenomenon of self-cutting renders it ambiguous. The Conclusion describes the significance of this shift in broader terms: the displacement of overdosing by the prominence of self-cutting; a psychological object embedded in the social setting replaced by one focused upon internal, individual emotional struggles.

Concluding thoughts

The history of a particular psychiatric category is important because such categories are constitutive of human possibility. Hacking concludes that through these processes of (self) categorisation 'we are not only what we are[,] but what we might have been, and the possibilities for what we might have been are transformed'.[89] This history of cutting and overdosing in Britain can show how such coherences can come into use and how possibilities for identity are historically formed, linking the shifting analytical frameworks around self-harm to broader changes in cultural and political spheres.

This is important because, to quote Scott again, 'by exposing the illusion of the permanence or enduring truth of any particular knowledge ... [one] opens the way for change'.[90] The futures from which we are able to choose depend upon what we take to be the meanings of the past. If this position appears paralysing in stressing the multiplicity of the past, then it must also be able to demonstrate, in the words of Nikolas Rose, 'that no single future is written in our present'.[91] In this project, the people scrutinised, labelled, interviewed, referred, transferred, arrested, home-visited and otherwise assessed are made into and re-make these categories that render their behaviour somehow intelligible.

Finally, there are significant ethical implications for this kind of history. In showing how the meanings of the past and present are bound up with broader historical shifts, from social to internal, this book makes a point about the possibilities for change. For, if present meanings are the only valid ones, and history is merely an exercise in projecting those meanings backwards through time, history comes to naturalise the present, and offers nothing in the way of critical engagement. Instead, this book argues that the ways in which humans understand themselves and others are contingent, contextual and practical. The labels, and the kinds of labels, that we use have consequences that cannot be merely shrugged off by citing some eternal, intractable undercurrent, that validates (and is validated by) the imposition of current terms onto the past. Not only must we take responsibility for the descriptions that we use, it is incumbent upon us to be aware of how they fit into – and naturalise – broader transformations in thought and practice. The displacement of 'the social' (and with it much of the post-war welfare settlement) is a matter of great concern that this book, in its own small way, attempts to address. I am also concerned at the increasing reduction of human potential to biology and neurology in contemporary neuroscience, and the ways in which scientistic and

neo-liberal business practices are being used to discipline and neuter the critical functions of higher education. This book takes as its method Foucault's notion of historical critique, which

> is not a matter of saying that things are not right as they are. It is a matter of pointing out on what kinds of assumptions, what kinds of familiar, unchallenged, unconsidered modes of thought the practices that we accept rest.[92]

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