PSYCHIATRIC 'SURVIVOR' KNOWLEDGE AND TESTIMONIES OF SELF-HARM

Mark Cresswell,
Department of Sociology,
University of Manchester,
Room 2.45, Williamson Building,
Oxford Road,
Manchester
M13 9PL

e-mail: mark.cresswell@stud.man.ac.uk

UK 'Psychiatric Survivors' – a social movement grouping consisting of individuals who have been on the 'receiving end' of psychiatric treatment – have, since the mid-1980's, constituted a challenge to the psychiatric system. 'Survivors' have formulated their own knowledge-base concerning a range of human problems hitherto regarded as the province of 'official' psychiatry only. 'Official' knowledge stresses 'scientific' classification, professional expertise, and statistical evidence; 'Survivor' knowledge, by contrast, emphasises individual experience, the traumas of the lifecourse, and the personal testimony of the survivor as itself expert data. This paper focuses upon the 'testimony of the survivor' as an ingredient of survivor-knowledge. Specifically, I explore the public discursive outputs of female survivors whose behaviour has been officially labelled as 'deliberate self-harm'; that is, women who harm themselves, through self-poisoning or self-laceration, and subsequently receive medical/psychiatric treatment. The main focus is upon the political functions of testimony - the ways in which survivor-knowledge challenges the power of psychiatry.

1 Introduction

This paper is about a contested social institution - psychiatry - and some of the people who resist its power. It is also about unspeakable bodily acts – self-mutilation and self-poisoning – and some of the people who engage in and speak out about them.

My purpose is to demonstrate how a particular kind of truth-claim, which I call *testimony*, is articulated within a recent form of political practice. That practice occurs within the context of resistance to the power of psychiatry; specifically, in the form of resistance by *self-harm survivors* to the various interventions which psychiatry deploys upon them. By the term 'self-harm survivors' I am referring to the self-definition of individuals who engage in self-injurious behaviours (e.g. self-mutilation, self-poisoning) which bring them into contact with psychiatric services. Within mainstream psychiatry, the sorts of behaviours I'm referring to are categorised under the rubric *deliberate self-harm* and have been the target of research, 'treatment', and public health concern for more than fifty years.[1]

The main argument advanced is that 'testimony' constitutes a key component of the knowledge and practice of self-harm survivors and, as such, is a productive feature of their resistance to the power of psychiatry. This argument is illustrated by reference to a key publication of the self-harm survivor movement from 1994.[2] I keep to a UK context throughout and a periodisation which surveys the decade 1986-1996.

---

[1] A standard formal definition of DSH is that adopted by the World Health Organisation/European Multi-Centre Study, i.e.:'An act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm. Or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences.' S. Platt *et al,* 'Parasuicide in Europe: the WHO/EURO multicentre study on parasuicide. I. Introduction and preliminary analysis for 1989, *Acta Psychitr Scand*, 1992, p. 99.

[2] Louise Roxanne Pembroke (Ed), *Self-Harm: Perspectives from Personal Experience*, London: Survivors Speak Out, 1994. Abbreviated in this paper as *SHPPE*.

2. Self-harm survivors and UK psychiatry 1986 – 1996

This periodisation is chosen to demarcate the first wave of self-harm survivor activism in the UK.

The years 1986-1988 saw the establishment of two collectives – 'Survivors Speak Out' (SSO) and the 'Bristol Crisis Service for Women' (BCSW) - which provided some of the key personnel and knowledge resources serving the nascent self-harm survivor movement; whilst in March 1995, Louise Roxanne Pembroke, an activist intimately connected to both groups, called for the setting-up of a National Self-Harm Network (NSHN) in order to campaign more effectively for 'rights for self-harmers'.[3] NSHN was established shortly afterwards with Pembroke the first Chair. I take its constitution as the first national advocacy organisation for self-harmers as closing the first phase of activism in this area. In addition to the publication of the Pembroke edited *Self-Harm: Perspectives from Personal Experience (SHPPE)* in 1994, the other key date to consider during this period is September 5th 1989, the day of 'Looking at self-harm', the first national conference on self-harm to be held in the UK, 'entirely organised by the recipient movement'.[4] Some of the personal testimonies contributed from the platform that day were reproduced five years later in Pembroke's collection. It does seem that a compelling case can be made for holding September 5th 1989 to be the birth date of the self-harm survivor movement; but it may also be viewed, in historical context, as the middle of five milestones which mark this first period:

- 1986 – formal constitution of SSO.
- 1988 – BCSW starts to run a national telephone help-line for women.

[3] Louise Pembroke, 'National self-harm network', in *Openmind*, 73 Feb/March, 1995, p13.
[4] 'Survivor News', in *Asylum; a magazine for democratic psychiatry*, Vol. 4, No. 1, Oct. 1989, pp. 16-17. At this time 'recipient' was a term of self-definition employed by the 'user movement' alongside 'survivor' and 'service user'.

- 1989 – first national 'survivor' conference on self-harm.
- 1994 – publication of *SHPPE*, edited by Louise Roxanne Pembroke
- 1995 – formal constitution of NSHN.

The 1989 conference was an emotive event. One speech in particular has entered into survivor folklore and is worth considering for the light it sheds on the genealogy of the movement and some of its core arguments. This is Maggy Ross's 'Silent Scream' speech:

> 'I'm Maggy and I started to cut my body 5 years ago. I go to casualty and get hauled onto the psychiatric bandwagon. I am then given a nice little 'label'. The current label is Schizophrenia. That's how the professionals see me. I'm a self-destructive Schizophrenic. But how do I see myself? I am a survivor of sexual abuse and a survivor of the system. I know why I self-injure. When I feel I am losing control, I reach for a razor and prove to myself that I can have control over my body. When I am lost for words, my cuts speak for me. They say – look – *this* is how much I'm hurting inside...I'll tell you what self-injury isn't - and professionals take note. It's not attention seeking. It's not a suicide attempt. So what is it? *It's a silent scream.* It's a visual manifestation of extreme distress. Those of us who self-injure carry our emotional scars on our bodies.'[5]

Maggy Ross was, in fact, a founder member of BCSW along with Diane Harrison, who also addressed the 1989 conference. BCSW had formed as a result of a busy period of feminist activism in Bristol dating from the year 1986.[6] A number of Bristol-based women's mental health groups emerged in this period one of which explored the possibility of setting up a crisis telephone helpline for women, run by women. Maggy Ross and Diane Harrison, both self-harmers who had extensively 'used' psychiatric services, were part of this planning group, which included at least four other women who self-injured.[7] The group seems not to have been exclusively comprised of self-harmers and the subsequent telephone crisis line was not targeted

[5] *SHPPE* pp 13-15, second emphasis added. This is an edited version.
[6] See Tamsin Wilton, 'Madness and Feminism: Bristol Crisis Service for Women' in Gabriele Griffin Ed, *Feminist Activism in the 1990's,* London & Bristol: Taylor & Francis.

[7] In her 1988 magazine article 'Shocking Habit', which includes interviews with the self-harming members of the working group, Maggy Ross refers to 'Jane, Sally, Holly, Anne and Diane' That's six, including herself.

just at them either – but when the service became operational in January 1988 it quickly developed a specialist focus.[8] In that year also, Maggy Ross wrote a magazine article called 'Shocking Habit' which outlined some of the issues faced by women who self-harm and included disclosures from members of BCSW. In her speech at the 1989 conference she claimed to have received 500 replies to this article and commented, 'Now I know for a fact that we are not alone'.[9]

The conference itself had been organised by Louise Roxanne Pembroke who was then the Education Officer, later to be Secretary and Chair, of SSO. Formed also in 1986, SSO had quickly become the foremost user-led, user-run, networking group on the UK scene. Indeed, it signalled a 'new' type of 'service user' activism : 'new' in the sense of being active in response to a changing macro-political situation - service delivery systems were becoming increasingly embedded in urban communities rather than edge-of-city asylums[10] - and in the sense of innovating with 'new' ensembles of action.

It has often been pointed out that 'mental patient' activism did not come into being with SSO; there are clear precursors in the form of, to name the most prominent UK examples, the Mental Patient's Union (MPU) (1972-76)[11] and the Campaign Against Psychiatric Oppression (CAPO), formed in the early 1980's. What was truly 'new' about SSO, however, was that its activism revolved about the hub of a new theoretical category: *self-advocacy*.

---

[8] Ibid.
[9] *SHPPE*, p 14.
[10] See: Andrew, T Scull, *Decarceration: community treatment and the deviant - a radical view*, Cambridge: Polity; Peter Barham, *Closing the Asylum: the mental patient in modern society*, Harmondsworth: Penguin, 1992.

[11] See Nick Crossley, 'Fish, field, habitus and madness; the first wave mental health service users movement in Great Britain', *The British Journal of Sociology*, 1999, 50, 4, 647-670.

This concept proved to be of wide extension. It does not denote an invariant underlying ideology – such as may be expressed politically in the manifesto form[12] – but, rather, sanctions a range of actions consonant with a number of 'positions'. At first sight, SSO founder member Peter Campbell's definition of self-advocacy – 'the possibility and desirability of people speaking out and acting for themselves'[13] – seems insipid; that is, until we reflect upon the fact that for those deemed 'mentally ill' the historical impugnment of their rational capacity is a matter of notorious record. The main theoretical 'move' of the SSO activists, then, is a step backwards, away from the mandating of 'platforms of action' in the direction of buttressing the basic right of the 'mentally ill' to 'speak' their 'minds'. This forms the basis of SSO's oft-remarked 'pragmatism' – a pragmatism Peter Campbell has juxtaposed to the 'ideological' approaches of its precursors.[14] But it has not been sufficiently noted that such 'pragmatism' constitutes an 'ideology' all its own, and a familiar one. For in asserting the rational right to 'speak out', was SSO not in fact privileging that most venerable of Western '-isms', the liberal subject of humanism, that 'ground on which', as Thomas Szasz once opined, 'all free political institutions rest'?[15] On this view, SSO's pragmatism is hardly a depoliticisation; in fact, *it is the configuration of the condition of possibility for a type of political action and for a hitherto delegitimated type of political actor.*

Simple and powerful, the idea quickly gained a foothold:

[12] Both the MPU and CAPO produced 'manifestos' which served as basic statements of belief.
[13] Peter Campbell, 'The service user/survivor movement', in Craig Newnes et al (Ed), *This Is Madness: A critical look at psychiatry and the future of mental health services*, Ross-on-Wye, PCCS Books, 1999, p. 199.
[14] Peter Campbell, 'The history of the user movement in the United Kingdom' in Tom Heller *et al* (Ed*), Mental Health Matters: A Reader*, London Macmillan, 1996, p. 219.
[15] Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, London: Granada, 1981, p 269.

> 'In the space of 18 months or so [from 1985], it had taken over to such an extent that people in user groups…began to accept that what we were doing was indeed self-advocacy, and to talk about oneself and others as self-advocates.' [16]

The 'one step back' approach of SSO thus permitted support to be given to a diverse range of 'slates':

> 'SSO…has rarely campaigned on specific issues…but promoted the idea and principle of self-advocacy…People could set their own priorities.'[17]

This is why Campbell can claim that SSO, as an 'umbrella' organisation, encapsulates the more ideologically-minded CAPO, categorised as a 'national' and 'campaign' group, as well as locality-focussed campaign groups and user-run, self-help inspired service providers.[18] He classifies the developing women's mental health networks in Bristol, of which BCSW was an off-shoot, as 'a notable example of the latter.'[19]

This, then, is the social movement context in which Louise Pembroke, as member and 'officer' of SSO, organised the 'Looking at Self-Harm' conference in 1989, at which Maggy Ross, a founder member of BCSW, made her now 'legendary' intervention. But Pembroke brought much more to her role than her 'survivor' status and her commitment to self-advocacy. She herself was a 'self-harmer' who, by her own account, had first 'attempted suicide' aged 17, at which point she first came into contact with Accident and Emergency services and, later, psychiatry.[20] We know this because she tells us in her own section of *SHPPE.*[21] In an earlier article she described herself in this way:

---

[16] Peter Campbell, 'The Self-Advocacy Movement in the UK', in Anny Brackx and Catherine Grimshaw, (Ed), *Mental Health Care in Crisis*, London: Pluto, p. 206.
[17] Peter Campbell,1999: 199.
[18] Peter Campbell 1989, p. 210.
[19] Ibid., p. 211.
[20] *SHPPE*, pp. 30-31.
[21] *SHPPE*, pp. 31-60.

> 'I am a survivor of the psychiatric services. In the name of care and medicine I have been locked up, drugged, and subjected to ceremonial degradation.'[22]

Compare this with Maggy Ross:

> 'I am a survivor of sexual abuse and a survivor of the system.'[23]

And Diane Harrison:

> 'I am a survivor of self injury and sexual abuse.'[24]

These are certainly forms of self-advocacy, in Peter Campbell's terms, examples of 'people speaking out and acting for themselves'. But I also want to suggest that they are 'something else' as well.

- They are forms of speaking from the locus of the suffering 'I'.
- They constitute a serious claim to truth.
- They incorporate a knowledge forged in the direct experience of 'surviving.'

Later, another psychiatric self-harm survivor, Sharon Lefevre, will provocatively sum up the scope and nature of this truth-claim:

> 'As the writer and 'user' I can only give you my experience. I make no apologies for the explicit style in which I write and indeed ask for no approval. My aim is merely to endorse the experience as being 'real' and evidence of my 'truth'. The evaluation of this book, however, can only be validated by your agreement to believe in my 'truth.'[25]

I want to call such a truth-claim, together with the knowledge it incorporates, *testimony*.

---

[22] Louise Pembroke, 'Surviving Psychiatry', in *Nursing Times*, December 4, Vol. 87, No. 49,1991, p. 30.
[23] *SHPPE,* p. 13.
[24] Diane Harrison, *Vicious Circles; An exploration of Women and Self-Harm in Society*, London: Good Practices in Mental Health Publication, p 2.
[25] Sharon J. Lefevre, *Killing Me Softly: Self Harm Survival Not Suicide*, Gwynedd: Handsell Publications, p 6.

3. Testimony as truth-claim

This process - testimony - would doubtless have been subsumed by Michel Foucault under the rubric of 'confession'. For Foucault, 'the confessional' was a particular species of the genus 'truth producing practices', a species which had gained such ground in the West from the middle-ages onwards that, with characteristic gender blindness, he was moved to remark that, 'Western man has become a confessing animal.'[26] Nevertheless, Foucault's definition of 'confession' serves us well as a compass:

> 'The confession is a ritual of discourse in which the speaking subject is also the subject of the statement; it is also a ritual that unfolds within a power relationship…a ritual in which the expression alone…produces intrinsic modifications in the person who articulates it….'[27]

Testimony, on the other hand, is for Foucault a different technique within the West's arsenal of truth producing practices; it essentially consists in the 'testimony of witnesses'[28] and the juridical sphere is taken to be its paradigmatic field of application.

But consider the possibility that, in the case of 'survivors', the act of confessing *coincides* with that of testifying. What if they have become one and the self-same act? We are driven towards this recognition via Giorgio Agamben's consideration of the semantic interrelatedness of the triptych, 'testimony', 'witness', 'survivor':

> 'In Latin there are two words for "witness." The first word, *testis*, from which our word "testimony" derives, etymologically signifies the person who, in a trial or lawsuit between two rival parties, is in the position of a third party. The second word, *superstes*, designates a person who has lived through something, who has experienced an event from beginning to end and can therefore bear witness to it.'[29]

[26] Michel Foucault, *The History of Sexuality: An Introduction*, Trans. Robert Hurley, London Penguin, 1990, p 59.
[27] Ibid., pp 61-62.
[28] Ibid., p 59.
[29] Giorgio Agamben, *Remnants of Auschwitz: The Witness and the Archive*, New York: Zone Books, 1999, p 17.

As Agamben points out, these two meanings must not be swapped: the 'witness' who has 'lived through' an 'experience' is obviously not a third party to a dispute and cannot claim impartiality - 'he is a *survivor*… in every sense.'[30] On this view, 'testimony', in the sense of bearing witness to one's own lived- through experience, and 'confession', marry up: the survivor is the witness to their own experience, to which they testify, i.e. they are the 'speaking subject' who is also 'the subject of the statement'. The insertion I wish to make here is to suggest that, for psychiatric survivors, testimony itself be considered a branch of self-advocacy.

We might understand both this wider ambit I want to accord self-advocacy and the specificity of survivor testimony by expansion of the central category of 'direct' or 'lived-through' experience. If self-advocacy is the form that survivor-activism takes, then 'direct experience' is the 'well' of knowledge from which it is drawn – it is the 'what' about which survivors are speaking out. In survivor discourse it takes two forms, which correspond to two self-advocacy claims:

1. *Negatively*. 'Negative personal experience of mental health services' gives rise to 'legends of oppression', which, in the form of 'shared memories', are 'an important part of survivor culture.'[31] 'Legends of oppression' lie behind the very adoption of the 'survivor' label, taken on as an 'identity' -

> 'because we have *survived* an ostensibly helping system which places major obstacles across our path to self-determination.'[32]

[30] Ibid., my emphasis.
[31] Campbell, 'The service user/survivor movement', p. 197.
[32] Peter Campbell, 'A survivor's view of community psychiatry' in *Journal of Mental Health,* 1, 1992, p. 117, emphasis added.
.

'Legends of oppression' form the basis of survivors' theoretical-polemical critique of psychiatry which takes in, amongst other things, the validity of its knowledge-claims and the efficacy of its treatment strategies. In its weaker form, self-advocates claim that psychiatry doesn't help them; a stronger version claims that it causes them actual harm; stronger still is the call for psychiatry's 'abolition'. But in all cases the evidence offered is 'direct experience'.

2. *Positively*. But survivors don't rest just with 'what is wrong with current practice', they increasingly come to offer psychiatry advice as to improved service provision, 'workable alternatives'[33], even a new 'understanding…to the nature of distress.'[34] Whether such alternatives are offered in the spirit of radicalism or reform, the evidence supporting them is the same: direct experience. For survivors, the theoretical-polemical critique of psychiatry and the constructive alternatives offered are to be considered as credible challenges because survivors are, in effect, as 'expert' as the 'professionals' they criticise. They are 'experts by experience.'

Though what anchors self-advocacy is always 'direct experience', specific programmes of activism vary enormously including, to name but a few: taking part in consultation exercises with fund-holders; functioning as 'user-trainer-consultants' to psychiatric professionals; the production of 'charters' of 'users' 'rights'; the setting up of 'user-run' services. All these activities are fecund off-shoots of the function of self-advocacy. They are not all, however, examples of testimony. Self-advocacy has the wider compass.

The singularity of testimony, as Foucault clearly saw, is that 'the speaking subject is also the subject of the statement.' The affinity with 'confession', therefore, runs deep.

[33] Ibid., p. 117.
[34] Campbell, 'The service user/survivor movement', p. 201.

Though this form may play a minor role in the ensemble of survivor actions mentioned above – consultation, training etc. - it is not central to their articulation. In testimony, on the other hand, the suffering 'I' is, simultaneously, as Shoshana Felman has observed, 'the subject …and… the medium of…transmission.'[35] At the same time, whilst Foucault is correct that confession 'produces intrinsic modifications in the person who articulates it', intra-psychic modifications that carry over into survivor-testimony, in the process of testimony proper greater emphasis should be laid upon the aspect of 'ritual that unfolds within a power relation.' This requires analysis of that unfolding dynamic, an event which occurs between a survivor who gives testimony and the witness(es) who receive (hear or read) it.

So, consider the interaction: survivor-receiver, in the midst of the spatio-temporality of the 'testimonial situation', such as, say, being co-present at a survivor conference, or, where the receiver is the reader of a collection of survivor 'memoirs'. The 'receiver' is a witness to a testimony but they are not, to exploit Agamben's classification, strictly speaking either third party or survivor, though they are called upon to become the latter in one special sense, in that they do 'live through' the event that is testimony. Now, in order to fully grasp the specificity of testimony as a form of knowledge, we have to follow Felman in refusing to see survivor testimony as 'pure theory'[36]; in other words, the survivor does not just impart their historical knowledge 'onto' the receiver, which the latter 'takes in' like a *tabula rasa*. Neither is testimony a knowledge that has been formulated and rectified like a science. Rather, it is a polemic in the process of production, what Felman, following Foucault [37], calls a

[35] Shoshana Felman, 'Education and Crisis, Or the Vicissitudes of Teaching', in Shoshana Felman & Dori Laub, *Testimony: Crises Of Witnessing In Literature, Psychoanalysis, And History*, New York & London: Routledge, 1992, p. 5.
[36] Ibid.
[37] See Michel Foucault, 'The Will To Knowledge' in *Ethics; Subjectivity And Truth*, Ed. Paul Rabinow, Trans, Robert Hurley, London: Penguin, 2000, pp. 11-12.

'discursive practice.'[38] Testimony is neither the 'unthought' of 'common-sense' nor a science, but knowledge of the 'middle-ground', a place where that dense web of power and knowledge gets worked through in practice.

The 'receiver's' role in this must not be minimised. As Dori Laub has pointed out, 'Testimonies are not monologues.'[39] The witness to the testimonial event fully partakes in the production of its truth. Whatever the survivor has survived may be a fact, but it is not yet a 'known event'[40] until it has been witnessed in testimony. Laub concludes,

> 'The listener …is a party to the creation of knowledge *de novo*…Knowledge in the testimony is… not simply a factual given that is reproduced and replicated by the testifier, but a genuine advent.' [41]

Like confession, the practice of testimony unfolds within the confines of a power relation. Actually, from the perspective of the survivor, it is an attempt at rhetorical *force majeure*, which is why it 'comes on' as non-negotiable, as in Sharon Lefevre:

> 'I make no apologies…The evaluation…can only be validated by your agreement to believe in my truth.' [42]

The strident tone, however, belies the testifier's latent vulnerability for, if the 'truth' of testimony as a 'known event' is a co-production – Lefevre, endorsing the viewpoints of Felman and Laub, admits as much – then she stands in radical need of the receiver's assent:

> 'By virtue of the fact that the testimony is *addressed* to others the [survivor], from within the solitude of [her] own stance, is the vehicle of an occurrence…*beyond [herself]*.' [43]

---

[38] Ibid.
[39] Dori Laub, 'Bearing Witness or the Vicissitudes of Listening' in Shoshana Felman & Dori Laub, *Testimony: Crises Of Witnessing In Literature, Psychoanalysis,And History*, New York & London: Routledge, 1992, p. 70.

[40] Ibid. p 57.
[41] Ibid, pp 57 & 62.
[42] Levefre, *Killing Me Sotfly,* p. 6.
[43] Felman, 'Education and Crisis', p. 3.

Yet the receiver's dilemmas are of an equally 'needy' order. Called upon to validate testimony, the relation of receiver to survivor is not one of symbiosis: the receiver 'preserves his own special place.'[44] Bear in mind as well the various shades of 'receiver-ship': the receiver, who is called to bear witness to the testimony-event, may be themselves a psychiatric survivor, or else, a psychiatric professional, or even, a professional who is also survivor. SSO-organised conferences were explicitly conceived so as to bring, as Louise Pembroke put it 'survivors and workers' together.[45] Reflecting on the impact of Maggy Ross's legendary 'silent scream' testimony, it is not hard to imagine the 'mixed emotions' that might conceivably inhabit 'receivers':

> '[T]he latter comes to feel the bewilderment, injury, confusion, dread and conflicts that the [survivor] feels,' [46]

so that the issue of assent to the testimony becomes, for the receiver, a veritable trial of questioning. Is the testimony true? Or is it false? If it is true, then to what extent? Is *all* of it true? Or just a part? Is it *historically* true, in the sense that testimony makes reference to past happenings that in fact happened? Or is it 'only' experientially true, in the sense of referring to a sincerely communicated *felt*, but not verifiable, experience? What are the respective 'weights' to be accorded to historical and experiential 'truth'? Agamben has acutely summed up the dilemmas of testifying/receiving :

> 'What is at issue here is not…the difficulty we face whenever we try to communicate our most intimate experiences to others. The discrepancy in question concerns the very structure of testimony.'[47]

[44] Laub, 'Bearing Witness', p. 58.
[45] *SHPPE*, p. 4.
[46] Laub, 'Bearing Witness', p. 58.
[47] Agamben, *Remnants of Auschwitz*, p. 12.

On this account, survivor-testimony confronts us with a riddle, one which represents,

> 'the very aporia of historical knowledge: a non-coincidence between facts and truth, between verification and comprehension.'[48]

To paraphrase Agamben, then, the survivor-testimony-receiver dynamic finds itself necessarily mired in 'politico-ethical territory.'[49]

4. The political functions of testimony

Within this domain, testimony contributes to two political functions.

First, the *proselytising* function. Testimony is a powerful form of recruitment to the movement 'cause' insofar as the receiver, being called upon to co-produce the 'truth' of the testimony, is implicated in the ramifications of that 'truth'. In this scenario, survivor and receiver may enter into a relation of alignment - an 'alignment of witnesses.'[50] In such circumstances, the receiver may indeed assent to Sharon Levefre's invocation and 'validate' her 'truth'. Louise Pembroke describes an 'ideal-type' example of this in the case of a receiver who is a professional:

> 'For some of the health and mental health workers present…listening to the survivors brought about a U-turn of their feelings towards self-harm. One woman stood up and stated she had been taught that self-harm was always "attention-seeking". On realising that this was not the case she announced her intention to leave her job as she could not continue to work from that framework of belief.' [51]

Yet, in testimony, there is nothing automatic about the proselytising function; it often fails and may even provoke a backlash. That 'trial' of questioning, which the rhetorical *force majeure* of testimony provokes in receivers, may produce responses that are agnostic or invalidating from the survivor's point of view. Hence the

[48] Ibid.
[49] Ibid., pp. 11-14.
[50] See Felman, 'Education and Crisis', p. 2.
[51] *SHPPE*, p. 4.

possibility, emanating from the direction of receiver-professionals, of counter-allegations that 'professional users' are 'not representative' of 'patients' in general[52], or even that testimony is to be understood primarily as a 'clinical' event - the survivor has been witnessed acting out their own pathology.[53]

Of still greater import, however, is the *hegemonic* function. By 'hegemony'[54], I am referring to a political process in which powerful social particularities (groups, institutions, parties etc.) impose a *normative* order upon a given social field, thereby establishing norms which subsequently function as that field's 'definition of reality'. That 'definition of reality' then crystallises into the form of a 'hegemonic knowledge', for example, that raft of discursive practices called 'official' psychiatry, which is contingently susceptible of contestation by 'subjugated knowledges'[55], in this case, that of psychiatric survivors. The subsequent 'hegemonic struggle', to employ Ernesto Laclau's and Chantal Mouffe's terminology [56], is a battle over those very terms of reference that constitute 'reality'.

What, then, is the content of this 'hegemonic knowledge' that self-harm survivors seek to displace? Ever since the Austrian émigré psychiatrist Erwin Stengel inaugurated modern research into non-fatal self-injury in the UK in the early 1950's,

---

[52] Campbell, 'The service user/survivor movement', p. 201.

[53] Angela Trump on the *psychminded* website reports that this was sometimes the response Sharon Lefevre received during her workshops with professionals in which she would simulate sex with a doll as part of her theatrical testimony to reveal the connections between voice-hearing, self-harm and sexual abuse: http://www.psychminded.co.uk/critical/murray.htm

[54] The notion is, of course,associated with the work of the Italian Marxist Antonio Gramsci. Here, I am leaning heavily on its take-up by post - Marxist and and post-structuralist thinkers, i.e. Ernesto Laclau & Chantal Mouffe, *Hegemony & Socialist Strategy: Towards A Radical Democratic Politics,* London: Verso, 2001; Judith Butler, Ernesto Laclau and Slavoj Zizek, *Contingency, Hegemony, Universality: Contemporary Dialogues on the Left,* London: Verso, 2000.

[55] I.e. in Foucault's sense where 'subjugated knowledges' refer to 'a whole series of knowledges that have been disqualified as nonconceptual …knowledges that are below the required level of erudition or scientificity.' Michel Foucault, *Society Must Be Defended: Lectures At The Collège De France, 1975-76*, London; Allen Lane, 2003, p. 6.

[56] Laclau and Mouffe, *Hegemony and Socialist Strategy*, p. *xix*.

two questions have occupied psychiatrists.[57] First: to what extent should the act of self-injury – e.g. the paracetomol overdose/the slashed wrist – be considered a 'suicidal act'? Second, how is the act of self-harm to be considered in light of a notion of 'psychopathology', e.g. is it a symptom of an underlying mental 'disorder'? Hegemonic psychiatric knowledge, therefore, alternates between these two conceptual prisms – suicide/psychopathology – in its understanding of self-harm.

5. Testimony in action

Survivors attempt to shatter these conceptual prisms and, thereby, contest hegemony. They do so by attempting to sever the linkage between self-harm and suicide/psychopathology, instituting, in the resulting caesura, a series of displacements in which the nodal points of survivor-knowledge come to overlay those of psychiatry. This 'hegemonic struggle' engages survivor-testimony in support of the theoretical-polemical critique of psychiatry and the practices of self-advocacy in both their positive and negative guises.

The first severance is that of the act of self-harm with the question of suicide. Sharon Lefevre will later sum up the thrust of this approach with the mantra; 'self-harm - survival not suicide.'[58] But the distinction is already established by Louise Pembroke in *SHPPE*:

> 'There are two distinct types of self-harm. Firstly, self-harm with suicidal intent (or attempted suicide). Secondly. self-harm without suicidal intent…The second category…may lead to a suicide attempt but, in itself, is usually quite the opposite. An attempt at self-preservation.' [59]

[57] For the British debate on theories of self-harm see: Erwin Stengel and Nancy G. Cook, *Attempted Suicide: its social significance and effects*, London: Oxford University Press, 1958; Neil Kessel, 'Self-poisoning, I & II', *British Medical Journal*, 1265, 1336-1340 & 5473-5474, 1965; Norman Kreitman (Ed), *Parasuicide*, London: Wiley, 1977; Gethin Morgan*, Death Wishes; the understanding and management of deliberate self-harm*, Chichester: Wiley, 1979: Keith Hawton, *Attempted suicide: a practical guide to its nature and management,* Oxford: Oxford University Press, 1987.
[58] Levefre, *Killing Me Softly*. This is the subtitle of her book.
[59] *SHPPE*, p. 2.

The thrust of survivor self-advocacy is to displace the limit-concept 'suicide' in favour of 'survival'. This is clearly evident in both the theoretical-polemical parts of *SHPPE*,[60] where Pembroke advances her core arguments, the constructive sections where, for instance she prescribes a set of 'rights for self-harmers in Accident and Emergency departments'[61], and, of course, in the testimonies proper, including her own. So, early on she tells us that,

> 'Self-harm is a painful but understandable response to distress…Self-harm is about self-worth, self-preservation, lack of choices and coping with the uncopeable' [62]

whilst later she advises staff in Accident and Emergency:

> 'Try not to give the impression that you don't care and that you merely have to ascertain whether there is suicidal intent.' [63]

In the testimonies we witness 'Helen' telling us that,

> ' "Attention-seeking" or "attempted suicide" are just a couple of the 'professional' myths attached to self-harm. Suicide is final. Self-harm is a release from emotional pain and a struggle for survival.' [64];

and Pembroke herself:

> 'I need to self-harm in order to keep alive.'[65]

The second severance is that of the act of self-harm with the question of underlying 'pathology'. Survivors seek a displacement of this concept in favour of a generalised notion of 'distress'. 'Distress' is contiguous in the survivor lexicon to the notion of 'survival' and to 'direct experience' negatively conceived. But because no 'expression of distress', however 'negative' the source, as Pembroke says, is viewed

[60] *SHPPE*, pp 1-4 & 42-53.
[61] *SHPPE*,pp 54-58.
[62] *SHPPE* p. 1.
[63] *SHPPE,* p. 57.
[64] *SHPPE* p. 23.
[65] *SHPPE,*p. 37.

as either 'pathological or intrinsically [a] psychiatric phenomenon'[66], the way is open to bundle those acts which psychiatry subsumes beneath the label 'deliberate self-harm' along a spectrum of other 'socially acceptable' self-harming behaviours. Hence the employment of the 'continuum concept', a strategy which attempts to re-normalise what has been hitherto regarded as '(psycho) pathological' by establishing a continuity with normality:

> 'Socially acceptable forms of self-harm include: excessive smoking, drinking, exercise, liposuction, bikini-line waxing, high heels and body piercing.'[67]

The 'continuum concept' is a paradox which troubles any simple demarcation of the 'normal and the 'pathological'. For clearly, self-poisoning/self mutilation may be laid out along a continuum including 'socially acceptable' self-harming behaviours, as well as, as Maggy Ross noted, along a spectrum of other 'pathologised' behaviours:

> 'There are many ways of self-injuring – cutting up is just one. Anorexia and Bulimia are others. So's alcohol and drug abuse. Not to mention hitting things, burning or scalding oneself, or swallowing non-ingestants like bleach.'[68]

Additionally, all these behaviours may be laid out along one long spectrum together, in which case it is no longer clear whether all, some, or none are to be considered normal *or* pathological. 'Troubling' the psycho-pathological concept intentionally gestures at a 'clinical' reversal - the professional's assessment skills are re-directed upon *their own* self-harming behaviours. This is why Pembroke says of service providers:

> 'Self-harm mirrors painful or destructive elements they do not want to recognise in themselves…It's a bit too close to the bone…'[69];

[66] *SHPPE,* p. 31.
[67] *SHPPE,* p. 2.
[68] *SHPPE,* p. 14.
[69] *SHPPE,* p. 3.

and why, in one of the prescriptive sections of *SHPPE* - 'Suggestions for psychiatric counselling services' - she advises:

> 'Encourage staff to explore *their own* self-harm.'[70]

These various contiguous nodal points of survivor discourse – *survival, distress, direct experience* - may now be thrown into relief by posing an obvious question that has so far been held in abeyance: What are self-harm survivors actually 'surviving'? This leads us towards a specification of self-harm survivor activism/identity vis-à-vis 'psychiatric survivors' more generically conceived.

Of course, self-harm survivors do 'survive' as *psychiatric* survivors in SSO's terms:

> 'A growing number of mental health service recipients…are choosing to describe themselves as "survivors". This is partly because we survive in *societies* which *devalue…our personal experiences*…But it is chiefly because we have survived an ostensibly *helping system*…'[71]

They expand all the key (italicised) terms of this description but forgo the clause, 'but it is chiefly', in favour of establishing a relation of equivalence between 'societal survival' and 'system survival'. The mental health 'system', on this view, is conceptualised as a microcosm of the wider society. A self-harm survivor depiction of 'survival', along the lines of the above template, may be constructed in this way:

> 'A growing number of *women* are choosing to call themselves "survivors" because they are *driven to self harm* by a society that *violates them as children and adults*, *ignores their personal experiences*, then compounds the violation within an ostensibly helping *system that actually harms them*.'[72]

'Survival' is here seen not just in terms of the psychiatric system, but also in terms of the *gendered lifecourse*. The shift is distinctive and modifies the meanings attributed

[70] *SHPPE,*p. 56, emphasis added.
[71] Campbell, 'A survivor's view of community psychiatry', p. 117, emphasis added.
[72] This construction extrapolates from Louise Pembroke and condenses a number of testimonies in *SHPPE*: '[S]ocieties socialisation of women…encourages self-harm…To be driven…to tearing our bodies apart and having to endure services which compound the problem.' (p. 1).

to both 'societal' and 'system' survival. Society is seen as violating women in the double sense of 'socialising' them in such a way that their 'feelings' are constrained in an 'emotional corset'[73] and by exposing them as children to myriad 'abuses' – physical and sexual abuse, bullying – that ratchets the 'corset' tight. Hence, the salience of Maggy Ross's metaphor of the 'scream', which assumes the status of a survivor leitmotif:

> 'At home I was undergoing so much…abuse, I wanted to scream and scream…So I cut my wrist…It was like I was screaming without opening my mouth.'[74]

The core thought here is that 'violation' - for which the equation is: socialisation + abuse - causes emotions to be bottled up inside the person which are later released through self-harm. As Maggy Ross said:

> '[M]y cuts speak for me. They say – look – *this* is how much I'm hurting inside.'[75]

The 'system', in effect, reproduces this 'socialisation + abuse' equation. Expressions of 'feeling' are not only not facilitated on the psychiatric ward, but are further obstructed via the application of behavioural techniques and physical treatments, such as major tranquillizers, which control the body and dull the senses. Staff attitudes are experienced as 'sexist and heterosexist':

> 'I witnessed a greater propensity for sexual taunting and voyeurism…This abuse was presented as part of the 'treatment.'[76]

Psychiatric incarceration is itself regarded as one of the possible precipitants of self-harm. [77] Additionally, what also differentiates the role of self-harm survivors from

[73] *SHPPE,* p. 1.
[74] 'Marie' in *SHPPE*. p. 21.
[75] *SHPPE*. p. 13, original emphasis.
[76] Louise Pembroke in *SHPPE*. p. 34.
[77] This is the case for Louise Pembroke, Rosalind Caplin and Andy Smith (the only male self-harmer) in *SHPPE*.

generic survivors is the function of the Accident and Emergency department. Self-mutilation and self-poisoning are first medical, only later psychiatric emergencies. The ramification of this is that survivor knowledge and activism orients itself not only towards psychiatric but also to medical services. This is another facet of their 'system survival' and becomes an important focus of NSHN's later campaign work. A key claim of self –harm survivors is that,

> 'It is common to be stitched with no or inadequate anaesthesia, not having each layer of tissue properly stitched…These practices are widespread and must stop.'[78]

Self-harm survivor-identity, to sum up, may be viewed as distinctively structured in terms of a perceived double violation. In 'violation #1', the survivor is survivor of the gendered trauma of childhood; in 'violation #2' the survivor is survivor of those medical modes of intervention which are conventionally presented as 'treatments'. Generically-speaking, violation #1 is not emphasised or is absent for 'psychiatric survivors' where violation #2 is stressed, though in its narrower 'psychiatric' sense.

6. Conclusion

Undoubtedly, the practice of testimony is ancient. Its conditions of possibility are, in human terms, minimal: the existence of a power relation and the felt-presence of suffering together with a sign-system resourceful enough to communicate it. Probably, the most elementary hieroglyphic would suffice. The modern elaboration in the West, however, is diverse and its history would, I suggest, have to begin with the contrasting poles of the psychoanalytic encounter and the various genocidal conflagrations of the twentieth century.[79] Even in its more recent formulations, which may be associated with the rise of 'new social movements' from the 1960's onwards, its points of

[78] *SHPPE*, ibid. p. 3.
[79] See Judith Lewis Herman, *Trauma and Recovery: From Domestic Abuse To Political Terror*, London: Pandora, 1992.

dispersal, though not chaotic, are wide and any complete genealogy would have to include feminist activism of the second wave, gay liberation, and the plethora of 'survivor' movements mobilised around the twin foci of identity and health. In particular, there is an important genealogical link to be traced between feminist activism and survivor movements, between the testimonies of the self-harmers I've discussed here and the speak-outs and consciousness-raising activities of sexual assault victims, which Susan Brownmiller referred to as far back as 1975.[80] It is also necessary to track the patterns of connection and difference between psychiatric, sexual abuse and eating distress survivors, say, from 1980 onwards, a constellation of discourses which, to a large extent converge in the practices of the survivors I've studied here, but the detailed elaboration of which has been beyond my scope.

This paper has had a more modest ambition: to demonstrate the significance of testimony as a discursive practice of self-harm survivors; to draw the main historical outline of that movement in a restricted spatio-temporal sense; to sketch the rudiments of a theory of testimony as a political practice - as the always highly-charged activity of what Canadian psychiatric survivors Bonnie Burstow and Don Weitz once referred to as 'speaking true words.'[81]

[80] Susan Brownmiller, *Against Our Will: Men, Women And Rape*, Harmondsworth: Penguin, 1986, pp 7-9.

[81] Bonnie Burstow & Don Weitz, (Ed), *Shrink Resistant: the struggle against psychiatry in Canada*, Vancouver, BC: New Star Books, p. 22. Both Louise Pembroke and Diane Harrison were familiar with Bonnie Burstow's work. Pembroke references *Shrink Resistant* under 'Recommended Reading' in *SHPPE*. (P. 71); in *Vicious Circles,* Harrison offers Burstow's *Radical Feminist Therapy: Working In The Context Of Violence*, London: Sage, 1992, under 'Useful Reading' (p. 130). *Radical Feminist Therapy* contains a chapter on 'Self-Mutilation' (Ch. 10)