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Psychiatric "survivors" and testimonies of self-harm

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Abstract

UK "Psychiatric Survivors"—a variety of activist groups comprising individuals who have been on the "receiving end" of psychiatric treatment—have, since the mid-1980s, mounted 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 life-course, and the personal testimony of the survivor as itself expert data. This paper focuses upon the truth-claims enacted by the "testimony of the survivor" and the relation of "testimony" to political practice. Specifically, I analyse a key text containing the testimonies 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 in theory and practice—the ways in which "survivors" challenge the power of psychiatry.

Keywords: Psychiatry; Mental health; Survivors; Self-harm; Testimony; United Kingdom

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*,[1] 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 non-fatal self-injurious behaviours (e.g. self-mutilation, self-poisoning) which bring them into contact with medical services. Within mainstream psychiatry, the sorts of behaviours I am referring to are categorised under the rubric *deliberate self-harm*, defined as "self-poisoning or self-injury, irrespective of the apparent purpose of the act" (NICE, 2004, p. 16), and have been the target of research,

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[1]The concept of 'testimony' is, of course, not new; I lay claim to it here only in the limited sense outlined in the paper. It has been developed, sometimes extensively, within: religious studies (see Falcetta, 2003); the Latin American *testimonio* tradition (e.g. Menchú, 1983) and associated commentaries (e.g. Beverley, 2004); literary criticism (e.g. Felman & Laub, 1992); psychoanalysis (e.g. Felman & Laub, 1992); philosophy (e.g. Agamben, 1999); and Holocaust studies (e.g. Felman & Laub, 1992; Langer, 1991). This paper draws upon the work of Agamben and Felman & Laub.

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treatment, and public health concern for nearly 50 years (Stengel & Cook, 1958; Kessel, 1965, Kreitman, 1977; Morgan, 1979; Hawton, 1987; Hawton & van Heeringen, 2000). Deliberate self-harm is today a major cause of medical admissions for women and men in the UK (NICE, 2002).[2]

The main argument advanced is that "testimony" is a key component of the political practice of self-harm survivors and a productive feature of their resistance to the power of psychiatry. This argument is illustrated by reference to a key publication of self-harm survivor activists (Pembroke, 1994). Additionally, I consider some of the theoretical elements involved in the elucidation of testimony as a political practice.

The following section locates this practice within the UK context and subsequent sections expound the notion of testimony.

Background: self-harm survivor activism, 1986–1996

The years 1986–1988 saw the establishment of two collectives in the United Kingdom—Survivors Speak Out (SSO) and the Bristol Crisis Service for Women (BCSW)—which provided some of the key personnel and knowledge resources serving nascent self-harm survivor activism. With the advent of SSO in 1986, activists within the psychiatric field for the first time began to refer to themselves not as "patients", or "ex-patients", but *survivors*. Peter Campbell, a founder member of SSO, explained the new self-designation as arising, "because we have *survived* [italics added] an ostensibly helping system which places major obstacles across our path to self-determination" (Campbell, 1992, p. 117). The reference to the "system" is, of course, to the institution of psychiatry.

SSO signalled a new type of "mental patient" 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 (Scull, 1977; Barham, 1992), and in the sense of innovating with "new" ensembles of action. A central feature of SSO's activism was that it revolved around the hub of a new theoretical category: *self-advocacy*.

This concept proved to be of wide extension. It does not denote an invariant collective ideology—such as may be expressed politically in the manifesto form[3]—but, rather, sanctions a range of actions consonant with a number of political beliefs. At first sight, Peter Campbell's (1999, p. 199) definition of self-advocacy—"the possibility and desirability of people speaking out and acting for themselves" 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".

Simple and powerful, the idea quickly gained a foothold:

> 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. (Campbell, 1989, p. 206)

It was in this spirit of "self-advocacy" that Louise Roxanne Pembroke, then Education Officer, later to be Chair of SSO, organised the "Looking at self-harm" conference on September 5th, 1989. This was the first national conference to be held on the issue of self-harm organised entirely by survivors themselves (Asylum, 1989, pp. 16–17). The conference was an emotive event and a number of speeches made from the platform that day were delivered by members of another recently formed organisation, the BCSW.

BCSW was just one result of intensive feminist activism in Bristol dating from the year 1986 (Wilton, 1995). 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 had self-injured (Ross, 1988). Both Maggy Ross and Diane Harrison spoke powerfully at the 1989 conference and their contributions were later included in the Pembroke edited, SSO-produced publication, *Self-Harm: Perspectives from Personal Experience* in 1994. Maggy Ross's speech, in particular, became an emblematic public pronouncement of the self-harm survivors. This is the "Silent Scream" speech (Pembroke, 1994):

> 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

[2]The National Institute for Clinical Excellence (NICE) has recently commented that deliberate self-harm, "results in about 150,000 attendances at accident and emergency departments each year. It is one of the top five causes of acute medical admission" (2002, p. 2).

[3]Previous "mental patients" collectives such as the Mental Patient's Union (MPU) (1972–1976) had produced "manifestos" which served as basic statements of belief. For the history of the MPU see Crossley (1999).

(*footnote continued*)

> 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* [italics added]. It's a visual manifestation of extreme distress. Those of us who self-injure carry our emotional scars on our bodies. (pp. 13–15).

Louise Pembroke published the "Silent Scream" speech in the SSO collection in 1994. Pembroke's function in SSO and her subsequent founding of the National Self-Harm Network in order to campaign more effectively for "rights for self-harmers" (Pembroke, 1995, p. 13), make her the central figure of self-harm survivor activism in the decade 1986–1996. Yet she brought much more to her role than her SSO 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 came into contact with Accident and Emergency services and, later, psychiatry (Pembroke, 1994, pp. 30–31). We know this because she tells us in her own section of *Self-Harm: Perspectives from Personal Experience* (Pembroke, 1994, pp. 31–60). In an earlier article (Pembroke, 1991, p. 30) she described herself in this way: "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".

Compare this with Maggy Ross (Pembroke, 1994, p. 13): "I am a survivor of sexual abuse and a survivor of the system".

And Diane Harrison (1995, p. 2): "I am a survivor of self injury and sexual abuse".

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 self.
- They constitute a serious claim to truth.
- They incorporate a knowledge forged in the direct experience of "surviving."

Later, another self-harm survivor, Sharon LeFevre (1996), will 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". (p. 6)

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

Testimony as truth-claim

This process—testimony would doubtless—have been subsumed by Michel Foucault under the rubric of "confession". For Foucault (1990, p. 59), "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". Nevertheless, Foucault's definition of "confession" serves 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. (pp. 61–62)

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" (Foucault 1990, p. 59) 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 Agamben's (1999) 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. (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* [italics added]… in every sense" (Agamben, 1999). On this view, "testimony", in the sense of bearing witness to

one's own 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".[4] 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 this wider ambit I want to accord self-advocacy and the specificity of survivor testimony by expansion of the central category of "direct 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 speak 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"(Campbell, 1999, p. 197). "Legends of oppression" lie behind the very adoption of the "survivor" label, taken on as an identity: "because we have *survived* [italics added] an ostensibly helping system" (Campbell, 1992, p. 117). "Legends of oppression" form the basis of survivors' polemical critique of psychiatry which takes in the validity of its truth-claims and the efficacy of its treatment strategies. In its weaker form, self-advocates claim that psychiatry does not 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 do not rest with criticisms of current practice; they increasingly come to offer psychiatry advice as to improved service provision, "workable alternatives" (Campbell, 1992, p. 117), even a new "understanding…to the nature of distress" (Campbell, 1999, p. 201). Whether such alternatives are offered in the spirit of radicalism or reform, the evidence supporting them is the same: direct experience. For survivors, the 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, programmes of activism are varied and include: 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 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, as it does with what Arthur W. Frank (2002), from a different perspective, calls personal "narratives" or "stories".[5] Though this form may play a minor role in the ensemble of survivor actions mentioned above, it is not central to their articulation. In testimony, on the other hand, the suffering "I" is, simultaneously, as Shoshana Felman (1992, p. 5) has observed, "the subject…and… the medium of…transmission". At the same time, whilst Foucault is correct that confession "produces intrinsic modifications in the person who articulates it", in the process of testimony greater emphasis should be laid upon the aspect of "ritual that unfolds within a power relationship." This requires analysis of that *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.[6] The receiver is 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. In order to grasp the specificity of testimony as a truth-claim, we have first to see it as a *performative* discourse, not as, say, an expression of autobiographical fact. A performative discourse[7] is one that strives to bring into being a state

[4]The differentiation between the functions of "witness", "survivor", "testifier" and their designation as either "confession" or "testimony" is complex and cannot be adequately addressed in this paper. I have confined myself to an analysis of the political functions of "testimony", as I have defined it. One consequence of this is that the role of *guilt* and *shame*, as intra-psychic and intersubjective phenomena, is eschewed. The functions of guilt and shame, in the context of the confession/testimony nexus, strike me as significant and will need to be addressed in future work. I am indebted to an anonymous referee for *Social Science and Medicine* for making this point.

[5]I do not have the space to elucidate the similarities and differences between my use of "testimony" and Frank's development of the notions of "narrative" and "narrative analysis."

[6]Of course, I do not mean to suggest that the speech act and the act of writing, or of listening and reading, are equivalent. I do not have the space to enter into the important distinctions vis-à-vis "testimony" in this paper.

[7]The discussion of 'performatives' draws upon the work of Austin (1962) and Butler (1997). My usage stresses the political function of 'performatives' but there is not space here to differentiate this usage from those of Austin's and Butler's.

of affairs rather than to report a past or present occurrence. In testimony, the survivor does not express her unique historical knowledge, which the receiver accepts as a "given". Rather, testimony aims to bring into being a state of affairs in which the survivor's truth is witnessed as an event about which "something ought to be done". In "surviving" the performance of testimony, the receiver is simultaneously called upon to do something about it. That is testimony's political point.

It follows, then, that receiver and survivor are *partners* in testimony; both partake in the production of its "truth". Whatever the survivor has survived may be a fact, but it is not yet a "known event" (Laub, 1992a, p. 57) until it has been witnessed in testimony. Dori Laub (1992a, pp. 57–62) 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".

Like confession, the practice of testimony unfolds within the confines of a power relationship. 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 the work of LeFevre (1996, p. 6): "I make no apologies…The evaluation…can only be validated by your agreement to believe in my truth". The strident note, 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 (1992), admits as much—then she stands in 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*]" (Felman, 1992, 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" (Laub, 1992a, p. 58). 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 a survivor. SSO-organised conferences were explicitly conceived to bring "survivors and workers" together (Pembroke, 1994, p. 4). Reflecting on the impact of Maggy Ross's (1994) legendary "silent scream" testimony, it is not hard to imagine the mixed emotions that might conceivably inhabit receivers: "the latter comes to feel the bewilderment, injury, confusion, dread and conflicts that the [survivor] feels" (Laub, 1992a, p. 58), so that the issue of assent to the testimony becomes, for the receiver, a trial of self-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 (1999, p. 12) 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".

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" (Agamben, 1999). To paraphrase Agamben: the survivor–testimony–receiver dynamic finds itself mired in *politico-ethical territory* (Agamben 1999, pp. 11–14).

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" (Felman, 1992, p. 2). The receiver may indeed assent to Sharon LeFevre's (1996, p. 6) invocation and "validate" her "truth". Louise Pembroke (1994) 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. (p. 4)

Yet, in testimony, there is nothing automatic about the proselytising function; it often fails and may even provoke a backlash. That self-questioning, which the rhetorical *force majeure* of testimony provokes in receivers, may produce responses that are invalidating from the survivor's point of view. Hence the possibility, emanating from the direction of receiver-professionals, of counter-allegations that "professional users" are "not representative" of "patients" in general (Campbell, 1999, p. 201), or even that testimony is to be understood

primarily as a "clinical" event—the survivor has been witnessed acting out their own pathology.[8]

Of greater import, however, is the *hegemonic* function. By "hegemony",[9] I am referring to a political process by which social 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 "truth", for example, that of "official" psychiatry, which is contingently susceptible of contestation by "subjugated knowledges" (Foucault, 2003, p. 6),[10] in this case, that of psychiatric survivors. The subsequent "hegemonic struggle", to employ Ernesto Laclau and Chantal Mouffe's (2001, p. xix) terminology, is a battle over those very terms of reference that constitute "reality".

What, then, is the content of this hegemonic truth that the subjugated knowledge of self-harm survivors seeks to displace? Ever since the Austrian émigré psychiatrist Erwin Stengel (1952) inaugurated modern research into non-fatal self-injury in the UK in the early 1950s, two questions have occupied psychiatrists. 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" (Felman & Laub, 1992, p. xv)—suicide/psychopathology—, in its understanding of self-harm.

Testimony in action

Survivors attempt to shatter these "conceptual prisms" and, thereby, contest hegemony. They do so by trying to sever the linkage between self-harm and suicide/psychopathology, instituting, in the resulting "slit", a series of displacements in which the key concepts of survivor-knowledge come to overlay those of psychiatry. This "hegemonic struggle" engages survivor–testimony in support of the 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 (1996) will later sum up the thrust of this approach with the mantra: "self-harm—survival not suicide."[11] But the distinction is already established by Louise Pembroke (1994) in *Self-Harm*: *Perspectives from Personal Experience*:[12]

> 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. (p. 2)

The thrust of survivor self-advocacy is to displace the concept "suicide" in favour of "survival". This is clearly evident in both the polemical sections of *Self-Harm* (pp 1–4 and 42–53), where Pembroke advances her core arguments, the prescriptive sections where, for instance she advocates a set of "rights for self-harmers in Accident and Emergency departments" (pp. 54–58), 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" (p. 1), whilst later she advises staff in Accident and Emergency Departments: "Try not to give the impression that you don't care and that you merely have to ascertain whether there is suicidal intent" (p. 57).

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" (p. 23); and Pembroke herself: "I need to self-harm in order to keep alive" (p. 37).

The second severance is that of the act of self-harm with the assumption 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 (1994, p. 31) says, is viewed as either "pathological or intrinsically (a) psychiatric phenomenon", 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

[8]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.

[9]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 post-structuralist thinkers, e.g. Butler, Laclau & Žižek, 2000; Laclau and Mouffe (2001).

[10]I.e. in Foucault's (2003, p. 6) 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".

[11]This is the subtitle of LeFevre's 1996 book, *Killing Me Softly*.

[12]This publication is shortened in the text to *Self-Harm* from this point on.

of a *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" (p. 2).

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 (1994, p. 14) 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".

Additionally, all these behaviours may be laid out along one long continuum 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 (1994, p. 3) 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"; and why, in one of the prescriptive sections of *Self-Harm*—"Suggestions for psychiatric counselling services", she advises: "Encourage staff to explore *their own* [italics added] self-harm."

All aspects of survivor-knowledge—polemical/prescriptive/testimonial—are here engaged in the hegemonic struggle. The rhetorical *force majeure* of testimony, however, makes a specific contribution in counter-posing the alter-reality of the survivor lexicon for that of the psychiatric. It may do so because, like Foucault's (1990) "confessional", testimony is a *personalised* discourse: the receiver is not only brought tidings of suffering, those tidings are spoken by the subject of suffering herself. What is more, there is a *visceral* element involved in this personalisation: to modify Foucault:

> Testimony is a ritual of discourse in which the speaking, suffering subject is also the subject of the statement; and in which the suffering of which she speaks is inscribed by herself upon or within her *body*—of which act she then speaks.

Or, as in the opening of the "Silent Scream" speech in *Self-Harm* (1994, p. 13): "I'm Maggy and *I started to cut my body* [italics added] 5 years ago".

The impact is affective, but also visceral and not just cognitive; it is not the same as, for example, the presentation of third person vignettes. In this visceral impact of testimony inheres the capacity to shatter the "conceptual prisms" of hegemonic truth—an immediate effect that has often been noted, e.g. of the 1989 conference: "one of the most *upsetting* [italics added] and also encouraging events with which recipients have been involved in the last 4 or 5 years. The personal contributions from people who self-harm…was *devastating* [italics added]" (Asylum, 1989, p. 16).

This visceral impact permeates the experience of testimony as a *performative* discourse. The performance of testimony triggers a crisis for survivors and receivers, a moment of danger but also (perhaps) of revelation. For the receiver, the upshot may be transformative: a "conceptual breakthrough" (Laub, 1992b, p. 85), one that makes trouble for taken-for-granted assumptions. It is to this process which Felman and Laub (1992, p. xv) refer, when they comment that testimony provokes the production of "nonhabitual…conceptual prisms, through which we attempt to apprehend…the ways in which our cultural frames of reference and our pre-existing categories delimit and determine our perception of reality".

It is this potential to shatter the mental habits subtending hegemonic practices that imparts to testimony its political promise. Yet, like confession, testimony occurs within the context of a power-relation in which assent can be both granted and denied; in which the possibility exists of retroactively "trashing", not endorsing, the survivors' truth-claim.

As with the proselytising function, then, testimony's singular impact may be equally productive of a hegemonic counter-offensive, which seeks to erase, not to align with, key survivor concepts.

Performative violations

These concepts—*survival*, *distress*, *direct experience*—may now be thrown into relief by posing a question that has so far been held in abeyance: What are self-harm survivors actually "surviving"? This question revises two specifications: the place of testimony within the ensemble of self-advocacy practices; and its function in the hegemonic struggle.

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* [all italics added]. (Campbell, 1992, p. 117)

Self-harm survivors expand all the italicised terms of this description but forgo the clause, "but it is chiefly", in favour of establishing a synecdochical relation between "societal survival" and "system survival". The mental health "system", on this view, is conceptualised as a microcosm of the wider society whilst, at the same time, the "system" is writ large in "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*.[13]

"Survival" is here seen not just in terms of the psychiatric system, but also in terms of the *gendered life-course*. The shift is distinctive and modifies the meanings attributed 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 become constrained in an "emotional corset" (Pembroke, 1994, p. 1) 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."[14] It is not the case that only overt "abuse" produces the "scream"; for "societal survival" posits the "normal" socialisation process, by which girl becomes woman, as itself constituting a form of "abuse":

> Not everyone who self-injures has been sexually abused, but all the women I have worked with and have spoken to, talk about feeling invalidated in a world full of grown ups where no one talked about their feelings, where anger and violence…lingered in the atmosphere (Harrison, 1995, p. 15).

The core thought here is that "violation"—for which the equation is: socialisation + abuse—causes emotions to be caged up inside a woman, which are later released through self-harm. As Maggy Ross (1994, p. 13) said: "my cuts speak for me. They say—look—*this* is how much I'm hurting inside".

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 tranquillisers, 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'" (Pembroke, 1994, p. 34).

Psychiatric incarceration is itself regarded as one of the possible precipitants of self-harm.[15] Additionally, what differentiates the role of self-harm survivors from other psychiatric 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 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 the National Self-Harm Network's later campaign work (Pembroke, 1995). 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" (Pembroke, 1994, p. 3).

Self-harm survivor knowledge, to sum up, may be viewed as 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.

Negative and positive modes of self-advocacy certainly possess the overarching goal of addressing both violations—raising consciousness in the first place, then getting something done about them. But it is only in testimony that we experience violation in the "raw", an experience that reinforces its visceral impact. Testimony is the political practice devoted to the performance of such "violations".

Why say "performance"? Why not "expression"—as if testimony was the reporting back upon, not the conjuring up of, past violations, of which survivors' words are the truthful expression? Because in the political practice of testimony it is the (attempted) co-production of violations in the context of the testimonial event—with all its promise, all its threat—that takes aim at the heart of hegemony.

[13]This construction extrapolates from Louise Pembroke and condenses a number of testimonies in *Self-Harm* (1994), e.g.: "societies 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).

[14]The testimony of "Marie" in *Self-Harm* (1994, p. 21).

[15]This is the case for Louise Pembroke, Rosalind Caplin and Andy Smith (the only male self-harmer) in *Self-Harm* (1994).

Conclusion

Testimony is the performative politics of violations. It is probably significant that our own time has been referred to as "the age of testimony" (Felman, 1992, p. 53). It would be of interest to track this claim and its history. This paper has had a more modest ambition: to demonstrate the significance of testimony as a practice of self-harm survivors and to sketch the rudiments of a theory of testimony as a political practice—as the always precarious practice of what Canadian psychiatric survivors Bonnie Burstow and Don Weitz (1988, p. 22) once referred to as "speaking true words".[16]

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[16]Both Louise Pembroke and Diane Harrison were familiar with Bonnie Burstow's work. Pembroke (1994) references *Shrink Resistant* under 'Recommended Reading' in *Self-Harm* (p. 71); in *Vicious Circles* (1995), Harrison offers Burstow's (1992) *Radical Feminist Therapy*, under 'Useful Reading' (p. 130). *Radical Feminist Therapy* contains a chapter on 'Self-Mutilation' (Chapter 10).

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