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Sharon LeFevre (1953-1999): Self-Harm and the Ethics of Testimony

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Abstract

This article remembers the activism of Sharon LeFevre, a 'psychiatric survivor' activist of the late 1990s. LeFevre focused mainly on the issue of self-harm. The article contextualizes her activism within British social movement politics and then discusses it in terms of three contributions: first to the theory of self-harm; second to the ethics of the professional-service user relationship; and third to the politics of 'testimony'. Testimony refers to the use of the personal experience of suffering as a form of political intervention. Although LeFevre's activism was provocative, controversial, and even paradoxical, the article argues that it was significant in its time and remains relevant today for the resources it provides to critique contemporary psychiatry, particularly the treatment of self-harm.

Key Words: self-harm, survivor, testimony

Introduction

Sharon LeFevre was a British psychiatric survivor activist of the mid-to-late 1990s. She campaigned to raise awareness about what British psychiatrists at the time called 'deliberate self-harm', which included self-poisoning (such as taking an overdose) and self-injury (such as cutting the body with a sharp object). She took her own life in 1999 at the age of 46. Although her career as an activist was short, LeFevre's contribution in the years immediately preceding her death should be remembered, especially for the challenge she posed to the ethics of mental health professionals, her provocative critique of the helping relationship, and her use of personal experience, or 'testimony', as a political intervention. She left an important work in her 1996 book, *Killing Me Softly,* subtitled*, Self-Harm – Survival Not Suicide*, a notable example of such testimony, but her other interventions of the period also established a lasting significance. Her activism remains both relevant and controversial.

The Social Movement Context

LeFevre's activism had a historical context. She came to prominence in the mid-1990s at the end of a decade that saw the emergence of the 'psychiatric survivor' movement in Britain, chiefly associated with the social movement organization Survivors Speak Out (SSO). Survivors were users of mental health services and SSO possessed both reformist and radical elements. Rejecting platforms based upon anti-psychiatry, SSO sought the reform of mental health services and the attitudes of psychiatric professionals, some of whom they accepted as allies. At the same time, they were radical in their promotion of non-medical paradigms for understanding mental distress, prioritizing the subjective experiences of survivors in contrast to psychiatric systems of classification. The concept of the 'psychiatric survivor' was SSO's own formulation. As defined by founder-member Peter Campbell in 1992, the meaning of the identification was as follows:

> '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 which places major obstacles across our path to self-determination'. (p. 117)

Survivor identity possessed two reference points. On the one hand, it looked backwards biographically to the experience of abuse and oppression which may have brought the individual into

contact with psychiatry in the first place; on the other hand, it reflected critically upon the 'care' encountered therein – 'care' that was part of a sometimes 'iatrogenic', or harmful, mental health system (Breggin, 1993). From the survivor movement emerged a number of organizations campaigning around diagnostic categories such as schizophrenia and self-harm; in addition to SSO, these included the Hearing Voices Network (HVN) (James, 2001), the National Self-Harm Network (NSHN) (NSHN, 2000) and the Action, Consultancy, and Training group (ACT) (James, 2001, pp. 98-102). LeFevre was part of the latter between 1995 and her death in 1999. Her activism can be divided into three parts: 1) a theory of self-harm; 2) a critique of the helping relationship; and 3) the use of personal testimony as a political intervention.

Self-Harm

In *Killing Me Softly* (1996) (hereafter, KMS)**,** LeFevre opposed the trend in psychiatry to develop its system of classification by removing the subjective content from it in preference for objective descriptions of individual behaviours. Successive versions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association (APA) are examples of this objectification (for example, APA, 1987). In the British context and in terms of self-harm, the definition given by the National Institute of Health and Care Excellence (NICE) is typical of such objectification: self-harm is defined by NICE simply as, 'acts of intentional self-poisoning or self-injury irrespective of type of motivation' (NICE, 2011, p. 5). By contrast, LeFevre restored the subjective content (including 'motivation') to her interpretation of self-harm. The opening and closing passages of KMS read like the antithesis of psychiatric objectification:

> 'I take out the towel…I take out the blades…I roll up my sleeve…I find the option of my stomach…I put the blade to my flesh and I slice it firmly…I look at the stream of blood dripping out…I reach into the cut and pull the skin flat and I slice the blade through the broken skin and it falls apart, like a mouth opening, wailing' (1996, pp. 88-89; also pp. 8-9).

This explicit account of subjective experience remains controversial for reasons outlined below. However, for LeFevre, exploring the subjectivity of self-harm formed the basis for an analysis of its causes and functions. In terms of causes, she linked self-harm's origins to the violations of childhood abuse, with the notion of abuse broadly conceived to include sexual, physical, and emotional abuse and neglect. From these causes, self-harm's functions emerged: if its origins lay in an experience of

victimization then the act of self-harm served an adaptive function. It represented the mid-point in a biographical transition 'from Victim to Victor', a phrase that was also the subtitle to a series of books published by ACT dealing with both hearing voices and self-harm (Coleman & Smith, 1997; Smith, 1998; Baker, Coleman & Taylor, 2000). Survival, then, for LeFevre was synonymous with self-harm and its function was to provide a transitional bridge, between victim and victor, a bridge that may be represented as follows:

VICTIM>>>>>>>>>>>>>>>>>>>>>>>>SURVIVOR>>>>>>>>>>>>>>>>>>>>>>>>VICTOR
(of childhood abuse) (through the act of self-harm) (over mental distress)

With this biographical transition in mind, it becomes possible to understand the subtitle of KMS – 'Self-harm – Survival Not Suicide' – for part of self-harm's adaptive function was to be found in its role as an alternative to self-destruction. This apparently counter-intuitive idea, that self-harm might be a means of suicide prevention, was a unique interpretation of psychiatric survivors. LeFevre did not originate it, for it is to be clearly found in the activism of Maggy Ross and Louise Pembroke in the late 1980s (Pembroke, 1994). LeFevre's contribution, however, was to provide the idea in KMS with additional substance and depth.

The Helping Relationship

If self-harm is a transitional bridge, then the possibility of therapeutic help becomes significant. Potentially, help could facilitate the transition from victim to victor. But whether it does or does not partly depends upon the ethical quality of the helping relationship. This was essentially LeFevre's argument and it posed a challenge to psychiatric professionals. That challenge may be described through a combination of her small body of published and unpublished writing and her use of dramatic performance as part of her activism.

LeFevre had a history of self-harm and a diagnosis of 'personality disorder'. When, in 1993, she was admitted to Dryll-y-Car, an innovative community care facility in Wales, she came into contact with three professionals who were allies of the survivor movement: psychiatrist, Phil Thomas, and senior nurses, Mike Greenwood and Ian Murray. This also brought her into the social network of Ron Coleman, founder member of ACT and prominent within the HVN. The activism of this network resulted in interventions that today would be called 'co-productions' (see Wharne,

2015): the Victim-to-Victor publications noted above; a conference roadshow spread out across eleven separate venues in England and Wales focusing on self-harm, abuse, and the voice-hearing experience; and a peer-reviewed academic article about the therapeutic environment of Dryll-y-Car co-authored by LeFevre, Greenwood, Murray, Thomas, and others (LeFevre et al., 1999). Such co-productions, however, uncovered dilemmas and paradoxes. As LeFevre et al. remarked in their *Health and Social Care in the Community* article, therapeutic relationships at Dryll-y-Car manifested 'a struggle that lies at the heart of the professional-service user *dialectic*' because, 'the type of staff-patient relationships required to provide 'person-centred' services are complex. They are neither expert-lay person nor simple friendships' (1999, p. 481, emphasis added).

Ethically, these dilemmas concerned the issue of the 'boundary' of the professional-service user relationship. If we set aside for the moment mainstream interpretations of this, as embodied, for example, in codes of professional conduct, and take seriously the notion that such relationships are, as LeFevre et al. argued, 'dialectical' – with 'dialectic' defined as 'two opposing tensions that strive towards unity' (Cresswell & Spandler, 2016, p. 357) – then LeFevre's perspective remains provocative. In terms of self-harm, it manifested itself in two ways: as an approach to the issue 'no self-harm contracts'; and in her interpretation of an attitude she detected in some psychiatric professionals, which she called 'spectatorship'.

No self-harm contracts, as a clinical intervention, had been introduced by the time LeFevre was using mental health services and remain in use today (O'Brien et al., 1985; Roush et al., 2018). Their underpinning idea is that the service user should agree not to self-harm, signifying this commitment via a signed undertaking. LeFevre's critique of such 'contracts' was uncompromising. First, the so-called 'contract', she argued, was not really a contract at all. Unlike a legal document in which two parties assumed rights and responsibilities backed up by a system of codified law, the no self-harm contract possessed no real juridical force. Moreover, the asymmetry of the power relations obtaining between professional and service user meant that, in practice, all the rights belonged to the former, and all the responsibilities to the latter. In one non-legal sense, however, the contract could be enforced if the service user failed to comply with their written commitment – in other words, if she self-harmed – in which case she might face a reduction in service provision or even an exclusion from it. For LeFevre, what lay behind the no self-harm contract was not the dialectical relationship she advocated but, on the contrary, the threat of punishment. 'Ultimately', LeFevre concluded (1996, p. 45, original emphasis), 'this is not *helping*, this is *bullying*.'

The illegitimacy of this 'contractual' approach was symptomatic of a limitation of psychiatry typically depicted in the classifications of the DSMs. LeFevre called this limitation 'spectatorship'. Spectatorship took the form of the professional's obsession with physical behaviours deemed 'risky'; in the case of self-harm, this manifested itself as the poisoned or bleeding body of the survivor. This attitude, however, failed to recognize self-harm's adaptive function and neglected the victimization that had caused the self-harm in the first place. Hence, by separating out the physical act of self-harm from the cause of the survivor's distress, the professional's therapeutic focus became exclusively behavioural: it focused solely on *stopping* self-harm to the detriment of the helping relationship. Spectatorship, then, went hand-in-hand with no self-harm contracts but in a wider sense also related to the development of suicide prevention strategies, which emphasized the predictive role that the physical act of self-harm played in a calculation of suicide risk. LeFevre's activism coincided with the development by British governments of population-based suicide prevention policies, which were predicated upon such a clinical approach to preventing suicide (for example, Department of Health, 1992). By contrast, LeFevre's subtitle to KMS – 'Self-Harm – Survival, Not Suicide' – signalled a conceptual separation of self-harm and suicide and sought to expose the spectatorship which, she argued, lay behind the emerging discourse of 'risk management'.

LeFevre's activism was controversial and paradoxical. The main example of this was a one-act play she authored and performed on the theme of self-harm. That drama, *On the Edge of a Dilemma* (hereafter, *Dilemma*), toured extensively in Britain between 1996 and 1998, playing mostly to audiences of psychiatric professionals. Its *dramatis personae* consisted of a male psychiatrist and a female psychiatric patient who self-harmed; the *mise-en-scène* was an in-patient ward. LeFevre cast herself in the role of the patient; her *actual* Dryll-y-Car consultant, Phil Thomas, played the psychiatrist. This became their most controversial co-production. Although the play itself has never been published, the reviews that survive document an 'astonishing' event (James, 2001a, p. 140). Thomas himself recounted how the curtain fall of one performance was met with a 'stunned silence' (in James, 2001b); and journalist Adam James noted how some scenes 'stirred up uneasiness amongst traditionalists' (James, 2001a, p. 140). That unease was triggered by the fact that the LeFevre/Thomas combination challenged the conventional boundaries of the professional-service user relationship; whilst a paradox emerged because, having condemned spectatorship in KMS as counter-productive to the helping relationship, LeFevre seemed, in the process of performing

Dilemma, to have encouraged it in her audiences. 'Particularly shocking,' James later remarked (2001b), was a scene in which, 'LeFevre removed her shirt to reveal rows of disfiguring scars.' The question here is whether LeFevre was trying to have it 'both ways': condemning spectatorship with part of her activism (KMS), whilst inviting it with another (*Dilemma*)?

Testimony

Had she lived longer, perhaps LeFevre would have answered this question herself. In any case, it can still be addressed in terms of the politics of 'testimony'. Testimony, in the sense of speaking out about personal experiences of abuse, has been applied to the experiences of psychiatric survivors in both SSO's senses of 'survival': 'because we survive in societies which devalue…our personal experiences…But…chiefly because we have survived an ostensibly helping system'. Since SSO's time, survivor testimony has taken many forms including conference speeches, written memoirs, and, in recent years, by deploying the resources of digital media. LeFevre's testimonies, however, were particularly provocative. 'As the writer', LeFevre declared (1996) at the beginning of KMS,

> 'I can only give you my experience…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)

Such testimony had political functions – but these too were paradoxical. On the one hand, the emotional impact of testimony could be such that it recruited professionals to the cause of the survivor movement; on the other hand, what James (2001, p. 140) called LeFevre's 'in-your-face' activism could also provoke a backlash or even increase the stigma attached to self-harm. More than one professional who witnessed LeFevre's performances seems to have concluded that she was acting out an 'extension of [her] pathology' (James, 2001c); whilst voices from within the survivor movement itself have since questioned whether the 'politics of the public display of scars and wounds' in fact invited a form of counter-productive voyeurism, which amounted to little more than 'medical pornography' (Pembroke, 2004, p. 11). The ethics of both testimony and spectatorship, it seems, are controversial and paradoxical but, whatever their pitfalls, it was these elements that LeFevre embraced in her activism.

LeFevre's Contemporary Relevance

Yet, partly because of these paradoxes, LeFevre remains relevant**.** There are two reasons for this.

Ethics of Testimony: There is no escaping the fact that testimony as a political intervention is fraught with controversy. It is part of what social movement scholars call a 'repertoire of contention' (Traugott, 1995); it is a way of contesting power – in the case of psychiatric survivors, the power of psychiatry. But unlike some aspects of the repertoire, it is double-edged. This makes it quite unlike petitioning, lobbying authorities, or seeking a change in the law and, consequently, it is likely to create just as many enemies as friends. It lends itself to artistic representation and, though *Dilemma* and LeFevre's conference appearances could be interpreted as counter-productive, such strategies are well-known in drama and more widely in art. One example would be Berthold Brecht's theatrical use of the 'alienation effect' designed to make the spectator a participant in the drama rather than a disinterested onlooker (see Gordon, 2017). In *Dilemma*, the provocative casting of LeFevre and Thomas can be seen in this way and if this is the case, instead of trying to have it 'both ways', LeFevre's incitement to spectatorship could be interpreted as an invitation to professionals to participate in rather than just 'spectate' upon, the professional-service user dialectic. LeFevre's legacy, then, through testimony, would be to encourage more interventions at this interface of psychiatry and art.

Professional/Service User Dialectic: Undoubtedly, LeFevre was critical of psychiatric professionals. Yet, unlike some proponents of anti-psychiatry (for example, Burstow, 2014), she did not advocate psychiatry's abolition. Her work, therefore, remains optimistically reformist and the space where that hope resides is in the relationship *between* the service-user and the professional: in the helping relationship. In this respect, her activism resonates with the early work of R.D. Laing (1975, 1990) and what he called the 'existential-phenomenological' tradition which explored the 'field' of 'inter-experience'. It could be said, then, combining LeFevre and Laing, that the field of inter-experience has dialectical possibilities, but whereas Laing explored this from the professional's side of the dialectic, LeFevre explored it from the service-user's side – especially where the service-user had politically identified as a psychiatric survivor (or, in terms of more recent social movements, as 'mad' (see Spandler & Poursanidou, 2019). It is in this sense that alliances between professionals and survivors constitute a 'politics of experience'. The politics of experience remains relevant today.

Recent debates on self-harm in Britain have not diminished but have, rather, augmented

LeFevre's arguments. In the research of Patrick Sullivan (2019), for example, on the treatment of individuals who self-harm in in-patient facilities, LeFevre's critique of spectatorship continues to resonate. Whereas LeFevre witnessed the origins of the 'risk society' culture (see Beck, 1992), twenty years later Sullivan describes it in its full development. The key features of this, as well as the focus upon 'risk management', are the dominance of legal and regulatory frameworks (the Human Rights Act 1998, the Care Quality Commission, litigation and negligence departments within healthcare organizations), which have the cumulative effect, Sullivan argues (2019, p. 62), of making it more likely that rigid and standardized procedures and increased levels of surveillance ('close observations') are employed to control individuals who self-harm, and less likely that 'therapeutically orientated' relationships are developed with service users which 'reflect the reality of their lived experience'. Re-considering LeFevre's activism today remains a provocative way of thinking about such developments.

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