Social Movements, Historical Absence, and the Problematisation of Self-Harm in the UK, 1980-2000

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Abstract

This article engages Bhaskar's category of 'absence' and Foucault's notion of the 'problematisation' in the context of explaining a historical emergence of political activism within the UK. Its contribution is at the interface of critical realism and social movement studies. The particular social movement considered is that of 'psychiatric survivors' in the form of the 'politics of self-harm'. The politics of self-harm refers to acts of self-injurious behaviour, such as drug over-dosage or self-laceration, which do not result in death and which subsequently bring individuals to the attention of psychiatric services. For many years survivors have protested about the harmful treatment ('iatrogenesis') they receive from such services and have campaigned for their reform and for new, non-psychiatric understandings of the meaning of self-harm. The article explains how such activism emerged in the late-1980s.

Keywords: social movements, absence, problematisation, psychiatric survivors, self-harm, iatrogenesis

Introduction

This article combines a theoretical framework derived from Roy Bhaskar's dialectical critical realism (DCR) and the later work of Michel Foucault with the subject matter of social movement studies. It extends a body of research into the sociology of 'psychiatric survivor'[1] political activism within the UK. Such politics, part of a wider field of health and medicine, has been called by Nick Crossley the 'field of psychiatric contention'.[2] Part of this research has focussed upon political activism which surrounds the diagnostic category of 'deliberate self-harm'[3] – self-injurious behaviours such as drug overdosing and/or self-laceration, which do not result in death.[4] For many years survivors have protested about the harmful treatment ('iatrogenesis') they receive from the National Health Service (NHS) and have campaigned for its reform and for new, non-psychiatric understandings of the meaning of self-harm. This activism has been characterised as the 'politics of self-harm'.[5] The present article continues this latter strand of inquiry, contributing to our understanding of the politics of self-harm whilst situating that understanding within the study of social movements.

Theoretically, the article offers a synthesis of DCR's central category of 'absence',[6] and the later work of Foucault, especially his account of the 'process of problematisation'.[7] This synthesis may be regarded as a DCR complement to those also concerned with the historical 'cycles' of social movements,[8] providing a particular emphasis upon explaining the emergence of political activism.

Psychiatry, Self-Harm and Social Movements

An understanding of psychiatry as a field of contention requires some preliminary clarification. First, in terms of psychiatry as a branch of medicine, which studies and clinically treats the 'mental' in contrast to the physical illnesses; and, second, as a specification of a field of power. Drawing upon a three-fold distinction derived from the later work of Foucault,[9] the field of contention may be understood as comprising three parts.

1. As a system of *knowledge*, its claim to scientificity is significantly lower than medicine[10] as evidenced by the lack of causal theories and biological tests for its main diagnostic categories (e.g. Schizophrenia);
2. As a field of legitimate *power*, it remains one of the only social fields in which an individual's liberty may be lawfully withdrawn, via the provisions of statutory legislation,[11] in the absence of a criminal offence;

[1] Referred to as 'survivors' after this.
[2] Crossley, 2006a
[3] E.g. Cresswell, 2005.
[4] See National Collaborating Centre for Mental Health, 2004.
[5] Spandler and Warner, 2007.
[6] Bhaskar's *Dialectic: The Pulse of Freedom* (2008) is the main theoretical reference point in this paper. After this it is just referred to as 'D'.
[7] The works referred to are: the second volume of *The History Of Sexuality* (1986); the late work referenced in Volume One of *The Essential Works* (2000a); and the late seminar series published as *Fearless Speech* (2001).
[8] E.g. Crossley, 2005; Traugott, ed, 1995.
[9] See The Essential Works, Volume One, 199-205, 262, and 318.
[10] See Cresswell, 2008; Pilgrim, 2013.

3. As an *ethical code*, it provides statutory provision for the administration of medical treatment without the individuals consent.[12] In these three aspects the contrast with general medicine is clear.

Given these aspects, it is reasonable to conceive of psychiatry as an institution of social control and as a manifestation of what Bhaskar refers to as Power2: an example of 'master-slave-type relations' of 'domination, subjugation and control'.[13] This point, however, should be carefully described; for the stereotype of the patient 'sectioned' under mental health law and forcibly treated with toxic medications, whilst real enough, fails to reference the contemporary scope of psychiatric power. As the latter part of the twentieth century witnessed a move away from an 'asylum' system of hospitalised care for the mentally ill[14] towards a system of 'community care', so psychiatry spread out to incorporate a range of everyday distresses such as 'anxiety' and 'depression' treated as much in the General Practitioner's surgery as upon the psychiatric ward. This has not led to a reduction of psychiatric power. Rather, it has led to the expansion of what Nikolas Rose called the 'psy-complex', considered as a diverse range of practices designed to manage the 'psychological self'.[15]

The phenomenon of 'deliberate self-harm'[16] should be understood within the context of the psy-complex. Although the definition of self-harm is contested, a psychiatric version may be given as follows. Self-harm is:

> a deliberate non-fatal act, whether physical, drug overdosage or poisoning, done in the knowledge that it was potentially harmful, and in the case of drug overdosage, that the amount taken was excessive.[17]

The connection of self-harm to completed suicide has long been researched.[18] Until 1961 it was legally classified as 'attempted suicide' and a criminal offence which could be punished by imprisonment. The *Suicide Act*[19] of that year decriminalized non-fatal self-harm and it became, thereafter, a psychiatric matter rather than a legal one. It remains so today. The epidemiology of self-harm is also significant: it is not rare and accounts for 'at least 200,000 general hospital presentations' per year in the UK.[20] Women are disproportionately affected, a fact which established self-harm as a political concern for feminist groups from the late 1980s.

This latter point is significant in considering how the psy-complex wields Power2. For it has been the case historically that manifestations of Power2 within the psy-complex have stimulated the resistance of Power1 in the form of what Bhaskar calls the

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[11] See The Mental Health Act, 2007: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_078743

[12] See Part IV of the Mental Health Act (1983) as amended by the Mental Health Act (2007). URL: http://www.legislation.gov.uk/ukpga/1983/20/part/IV

[13] D, 402.

[14] See Scull, 2005, 2014.

[15] See Rose, 1999.

[16] Referred to after this as just 'self-harm'.

[17] Morgan, 1979, 88.

[18] See Cresswell & Karimova, 2010.

[19] URL: http://www.legislation.gov.uk/ukpga/Eliz2/9-10/60

[20] National Institute for Health Research. URL: http://cebmh.warne.ox.ac.uk/csr/mcm/

'transformative capacity analytic to the concept of agency'[21], which in this article is associated with social movement activism. Where self-harm is concerned, this activism combined two forms from the mid-1980s onwards: first, survivor activism; second, feminist health activism. It is these forms of activism and a historical problem connected to their emergence that we discuss in this article.

Survivors and Self-Harm - A Problem of Historical 'Absence'

The political identity of survivors has been summarised by the activist, Peter Campbell. 'A growing number of mental health service recipients', Campbell observed,

> 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.[22]

This definition signifies a biographical experience in which the negative effects of an encounter with 1) personal trauma, are compounded by 2) harmful ('iatrogenic') psychiatric provision.[23] This two-stage experience constitutes both the collective identity of survivors and manifests itself in political demands upon the psy-complex. A significant literature now exists, both within academia and emerging from survivors themselves, concerning the history of these demands and the social movement organisations (SMOs) which mobilise them.[24]

As a part of this history, recent research has developed a historical analysis of the politics of self-harm. This contribution is structured as follows. Based upon archival research, the history of survivor activism in the UK is sketched between 1980 and the millennium. This history notes two features and one problem. The features are: 1) that the politics of self-harm emerged between the years 1986 and 1989 at the confluence of survivor and feminist activism; and 2) its central point of contention was the iatrogenic treatment experienced by self-harmers within the psy-complex. The problem is that the historical trail of this activism seems to go 'absent' when we consult the archives prior to these dates (before 1986).

The problem arises because both survivor and feminist activism are much in evidence prior to 1986 – yet there is no longer an activism recognisable as a politics of self-harm. The problem deepens once we consider the diversity of both forms of activism within a periodisation which stretches back to 1980. Survivors, for example, in the form of the SMO the Campaign Against Psychiatric Oppression (CAPO), were active around such issues as lawful incarceration and compulsory treatment; whilst feminists, in the form of the SMO Head On in Edinburgh, were active around such

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[21] D, 60.

[22] Campbell, 1992, 117.

[23] 'Iatrogenesis' is a significant concept in this article. The Oxford English Dictionary does not recognise the noun 'iatrogenesis' but gives 'iatrogeny' and the adjective 'iatrogenic'. The definition of the latter is: '[i]nduced unintentionally by a physician through his diagnosis, manner, or treatment; of or pertaining to the induction of (mental or bodily) disorders, symptoms, etc., in this way'. The noun 'iatrogenesis' is associated with the work of the sociologist Ivan Illich, particularly his 1976 text *Medical Nemesis*. Illich asserts: '[t]he medical establishment has become a major threat to health' (1976, 11). Illich's emphasis was upon threats to physical health but there is also a literature on psychiatric iatrogenesis often stressing the harmful effects of treatments such as electro-convulsive therapy (ECT) and anti-psychotic medications. The primary text upon psychiatric iatrogenesis is Peter Breggin's *Toxic Psychiatry* (1994).

[24] This paper has drawn particularly upon the digitised archives of the Survivors History Group (SHG): URL: (http://studymore.org.uk/mpu.htm).

experiences as anxiety and depression and the effects upon women of tranquilliser addiction. There is no shortage, then, of diverse mental health activism before 1986 but none of this concerned the politics of self-harm. This is the absence we seek to explain.

Questions, Theory, Method

The problem described, the next sections turn to its resolution. The main task is explaining the absence. It entails two questions.

Question 1: Why was there an absence of activism before 1986 concerning self-harm?

This question relates to the emergence of political activism insofar as, if an absence is to be replaced by a presence, some transformative conditions would historically need to be met. It presupposes a second question.

Question 2: What were those conditions and how were they met?

In addressing these questions, we engage two aspects of theory: one from within DCR, one from the later Foucault.

The first is Bhaskar's category of 'absence'. This is central not only for reasons of general ontology but because of its potential for explaining the emergence of political activism. On this reading, social movement activism may be defined as forms of dialectical praxis; that is as,

> argument, change or the augmentation of...freedom, which depend upon the identification and elimination of mistakes, states of affairs and constraints, or more generally ills - argued to be absences alike[25]...dialectics depends upon the positive identification and transformative elimination of absences. Indeed, it just is...the process of absenting absence'.[26]

Social movement activism, then, involves the identification and elimination of absence, with absence conceived as a constraint upon freedom, an experience of harm or, in the case considered here, iatrogenesis - where such harms are caused by $Power_2$ – (i.e. the psy-complex). Survivor activism ($Power_1$) is the politics of absenting absence within this particular field of contention.

This centrality of absence also suggests a method for solving our problem.[27] First, identify the specific absence(s) considered. Second, locate *where* they are absent; their 'determinate region of space-time'.[28] Third, explain the process of absenting absence: how an absence of political activism becomes a presence - a 'transformative elimination' of absence. Hence, the task of explaining our problem fundamentally rests upon absence. This, however, does not answer the second question above; specifically, it does not identify the historical conditions that need to be met to transform an absence into a presence. This is why the later work of Foucault enters the theoretical frame.

Foucault's value lies in his account of the 'process of problematisation', which specifies, at the level of human experience, the process of absenting absence. The process of problematisation shows how absence becomes presence: reflexive human experience registers the presence of $Power_2$ in the form of iatrogenesis then problematises what it has registered. To problematise $Power_2$ means not only to

[25] D, 393.
[26] D, 43.
[27] Here the article follows Bhaskar's 'basic schema of *applied* scientific explanation' (D, 133, original emphasis.)
[28] D, 38.

register the harm it has done but also to turn *that* into a problem that must be resisted. This is the first condition that needs to be met to transform an absence into a presence. The second condition concerns the presence of social movement organisations (SMOs) and interconnected networks capable of transforming the problematisation in human experience into Power1: the political agency which signifies social movement activism (survivor and feminist) and enters what Bhaskar calls the 'hermeneutic-hegemonic struggle'[29] with the psy-complex (Power2).

This method for solving our problem works by progressively analysing its chronological parts - absence followed by the historical conditions of absenting absence – finally permitting a 'regressive movement in which the initial phenomenon (the absence of a politics of self-harm) is redescribed in the light of its causes'.[30] This results in an answer to our first question: an explanation of absence.

First, however, we have to detail the historical problem which motivated such an approach in the first place.

The Politics of Self-Harm – Absence and Presence, 1980-2000

The politics of self-harm was 'born' in London on September 5th, 1989. This date may be stated precisely because it was the occasion of a significant event: the Looking at Self-Harm (LSH) conference organised by the social movement organisation (SMO) Survivors Speak Out (SSO).[31]

Why categorise LSH as the event of a 'birth'? Within the psy-complex there had been symposia on the issue of deliberate self-harm for decades. LSH, however, was different: it was, as the 'magazine for democratic psychiatry', *Asylum* remarked, 'an important first' – the first such event on the subject of self-harm to be 'entirely organised' by the survivor movement.[32]

That day bequeathed two statements which characterise the politics of self-harm.

First, from Maggy Ross, a feminist activist and founder member of the Bristol Crisis Service for Women (BCSW):

> [t]his day is crucial... It's a milestone because it's making self-harm a public issue at last. It's easy to lie about scars. Now though, if anyone asks me, I tell them what I do…I want to make them aware of the problem and…I want to enlighten them… Dialogue is crucial;[33]

then from Louise Pembroke, an activist within SSO:

> [t]he only way forward is to end the silence. For people with direct experience to share their experiences, and for dialogue to start between self-harmers and service agencies.[34]

The activism in evidence here is one which demarcates the public and private dimensions of a field of contention insofar as what characterises the politics of self-harm is the transformation of a private practice – the act of self-harm – into a presence in the public domain. Hence, the survivor invocation of 'dialogue', understood primarily as dialogue between the survivor and psy-complex professionals. The effect

[29] D, 66.
[30] D, 133.
[31] See Asylum, 1989, 16-17.

[32] Asylum, 1989, 16.

[33]Quoted in Pembroke, ed, 1994, 15.
[34] Pembroke, ed, 1994, 3-4.

is to inaugurate a politicisation of the meaning of self-harm - but a politicisation of a particular kind. For the politics of self-harm is not primarily a form of radical anti-psychiatry, but, rather, a form of activism aimed at democratisation, alliance and psychiatric reform.[35]

Taking Looking at Self-Harm (LSH) as a historical meeting-point, the politics of self-harm may be conceived as a way of looking both forwards and back. Looking forwards, LSH inaugurated a period of activism geographically centred upon London, Bristol and North Wales and, in terms of social movement organisations (SMOs), upon the National Self-Harm Network (NSHN),[36] constituted by SSO-activist Pembroke in 1995, BCSW continuing in Bristol, and the Action/Consultancy/Training group (ACT) based upon the work of the survivor-activist Sharon LeFevre in North Wales.[37] By the time we reach the millennium, the politics of self-harm was present across the public domain, not just confined within the discourses of the psy-complex, but in a series of wider ranging conferences and texts. The activism of NSHN provides evidence of this presence: in 1999 they staged two Risk Reduction conferences in London and Manchester. These conferences were, as Pembroke remarked, 'important milestones in the history of self-harm activism',[38] because they extended the scope of the public discourse on self-harm to include not only the professionals of the psy-complex but a diverse network of medics and para-professionals including medical students, accident and emergency clinicians, the British Red Cross and plastic surgeons.[39] The diversity of this public dialogue engaged in by NSHN et al is summarised in their book of 2000, *Cutting the Risk.*[40]

What happens, though, if we look historically back from LSH? Two findings emerge from the archives:

1. There is a public discourse on self-harm emerging from Bristol-based feminist activism – especially surrounding the founding members of the Bristol Crisis Service for Women (BCSW). This may be traced back as far as 1986 when, as Tamsin Wilton observed:

> three lesbians in a locked ward of a Bristol mental hospital began devising woman-centred alternatives to the 'mental health' services. From this developed…BCSW, a telephone helpline…for women in crisis, focusing particularly on self-injury.[41]

This move from an absence to a presence certainly culminates in Looking at Self-Harm (LSH) but it also demonstrates an antecedent process before LSH. In the period 1986-1989 Bristol-based feminists made interventions which, for the first time, moved self-harm from private absence to public presence by publishing in a women's lifestyle magazine,[42] a national broadsheet,[43] and appearing in a special edition of the daytime talk-show *Kilroy* themed around the issue of self-harm.

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[35] See McKeown, Cresswell and Spandler, 2014.
[36] See Pembroke, 1995.

[37] See LeFerve, 1996.

[38]URL: http://www.dbdouble.freeuk.com/harmminimum.htm

[39]See Davies, 2001.

[40] National Self-Harm Network, 2000.
[41]Wilton, 1995, 35.
[42] Ross, 1988.

Such feminist interventions had, however, been interconnected for some time with survivor activism. The archival evidence is plentiful here but, regarding self-harm, it requires careful description. Feminist activism certainly was not interconnected with survivors in terms of a politics of self-harm as a public discourse but it was interconnected considered in terms of a range of generic concerns which unite both forms of activism. Chief amongst these were:

- Shared 'legends of oppression'[44] referencing the iatrogenic effects of psychiatric hospitalisation, especially lawful incarceration and subsequent in-patient treatments such as forced medication and electro-convulsive therapy (ECT);[45]
- shared platforms in the conference or workshop formats. Certainly, in terms of a politics of self-harm this culminates in LSH, with the presence of both Survivors Speak Out (SSO) and BCSW, but it was present prior to that in terms of generic activism, particularly as evidenced in the annual conference of the national pressure group MIND of 1985 where precursors to BCSW, ran workshops in a programme which included the Campaign Against Psychiatric Oppression (CAPO) and soon-to-be SSO activists.[46]

2. This nascent public discourse about self-harm (1986-1989) of BCSW is the clearest antecedent of the politics of self-harm . If LSH does constitute the 'birth' of that politics then that birth cannot be an origin in an absolute sense but must itself be pre-dated by the interconnected networks of BCSW and SSO. We can certainly witness these connections in process of formation between 1986 and 1989 but, if we track back further than this, we can no longer detect either a politics of self-harm or, more surprisingly, any discourse at all about self-harm itself in either survivor or feminist activism. It is absent. This is a historical absence that needs to be justified.

Feminist Activism

Here, the evidence refers to the archives of primary sources at the Feminist Archive North (FAN)[47] and the Lothian Health Services Archive (LHSA).[48] FAN contains information about the activities of London-based feminist activism funded by the Women's Committee of the Greater London Council (GLCWC) between 1982 and 1986. This was a period of grassroots activism – the GLCWC's strategy being to award public funds to voluntary sector initiatives[49] – and amongst the relevant SMOs benefiting were: 1) Women's Action for Mental Health;[50] 2) London Women and Mental Health;[51] and 3) the Women's Health Information Collective.[52] From amongst

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[43]Hanson, 1988.

[44] Campbell, 1999, 198.

[45] See Women in Mind, 1986.

[46] See URL: http://studymore.org.uk/mpu.htm.

[47] URL: http://www.feministarchivenorth.org.uk/north.htm

[48] URL: http://www.lhsa.lib.ed.ac.uk/

[49] GLCWC, 1986, 8-9.

[50] GLCWC, 1984, 19.

[51]GLCWC, 1985a, 26-29.

[52]GLCWC, 1983, 9.

this activism, one example is especially relevant: the System Survivors' Writing Group, a sub-group of London Women and Mental Health, which identified a range of issues of political importance for women including:

- the treatment of lesbians;
- domestic violence and sexual abuse;
- the iatrogenic effects of electro-convulsive therapy (ECT);
- the iatrogenic effects of psychiatric hospitalisation.[53]

However, concerning the phenomenon of self-harm itself, amongst all of this activism, there was a literal silence.

Contemporaneously, the archive surrounding the group Head On in Edinburgh and located within the Lothian Health Services Archive (LHSA) also demonstrates a diversity of activism juxtaposed with the absence of any discourse at all about self-harm. Head On formed as part of the Scottish Women's Health Fair in September 1983 but was constituted of interconnected SMOs which pre-dated this including the Scottish Association of Mental Health, the Edinburgh and District Council on Alcohol and Scottish Women's Aid. These networks produced a range of workshops and leaflets covering the following themes:

- Women and Mental Health;[54]
- Women and Pills;[55]
- Women and Anxiety;[56]
- Women and Depression.[57]

Yet, again, in the midst of all of this activism, just as with the SMOs funded by the Greater London Council, there was no discourse at all about self-harm.

Survivor Activism

A similar pattern of presence and absence manifests itself if we examine the history of survivor activism in the years preceding the formation of Survivors Speak Out (SSO) (1986). In this case, the most relevant historical evidence is the digital archive of the Survivors History Group (SHG). Taking a periodisation 1980-1986, we find the following SMOs in evidence:

- PROMPT (the Protection of the Rights of Mental Patients in Therapy) – a group with an 'anti-psychiatry' manifesto, combining ideological elements derived from R.D. Laing[58] and Thomas Szasz[59] and which produced a series of leaflets, conferences and events.[60] PROMPT leaflet number 7, for instance', demanded the following 'rights' largely derived from the iatrogenic

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[53] GLCWC, 1985a, 26-29.

[54]Burns, McLaughlin and Richardson, 1983.

[55]Boyle, 1983.

[56]Crichton, 1983.

[57] Galloway, 1983.

[58]Laing, 1990.

[59] Szasz, 1974.

[60] URL: http://studymore.org.uk/mpu.htm#PROMPTbox

experience of psychiatric hospitalisation: 'retain and wear own clothing'; 'inspection of own medical records'; refusal of any treatment' etc.[61]

- CAPO (the Campaign Against Psychiatric Oppression) – a group which succeeded PROMPT and issued a militant-sounding manifesto:

> [t]ogether with other oppressed groups, victims of psychiatry, through [CAPO] must take collective action and realise their power in the class struggle alongside, trade unions, claimants unions…feminists etc.[62]

Yet, again, amidst all of this activism, there was no mention at all about the phenomenon of self-harm.

Summing up the evidence of this section, then, a periodisation may be established based upon the patterns of absence and presence noted above. Chronologically, this may be detailed as follows:

- **1980-1986** – there is an absence of a politics of self-harm and, simultaneously an absence of any discourse at all about self-harm itself - all of which is juxtaposed with diverse networks of survivor and feminist activism.
- **1986-1989** – there is the presence of activism about self-harm emerging within the Bristol Crisis Service for Women (BCSW) interconnected with certain activists from Survivors Speak Out (SSO) and a nascent, but not yet fully developed, politics of self-harm.
- **1989-2000** – self-harm fully emerges into the public domain with LSH and develops, in the decade to come, into a politics of self-harm with such SMOs as BCSW, the National Self-Harm Network (NSHN) and the Action/Consultancy/Training group (ACT).

Problematising Self-Harm

The history established, the first task in solving our problem is to identify the specific absence(s) discussed. These take two forms:

1. Chronologically, the first absence is that of any discourse at all about the phenomenon of self-harm in survivor and feminist activism in the period 1980-86.
2. The second absence is that of a public politics of self-harm in the period leading up to the Looking at Self-Harm (LSH) conference between 1986 and 1989.

These absences may be further specified. Although the first sounds like an instance of 'simple non-existence',[63] this is not the case. This is the significance of the question about the specific *location* of absence(s). The phenomenon of self-harm is absent between 1980-86 in a 'determinate region of space-time',[64] that is, the UK. This claim could be further delimited in terms of the determinate regions of space-time inferred from the archives scrutinised (Feminist Archive North [FAN], Lothian Health Services Archive [LHSA), Survivors History Group [SHG]) in which case the locations of absence would specify London and Edinburgh precisely. However, the wider geographical coverage which the SHG provides plus a decade-long research

[61] PROMPT, 1980, 38.

[62] See URL: http://studymore.org.uk/mpu.htm#CAPO

[63] D, 39

[64] D, 38.

programme into survivors[65] justifies a generalisation to the UK for the period in question. Yet this is still not a case of 'never anywhere existence'[66] existence because of the presence of the phenomenon of self-harm *external* to survivor and feminist activism, specifically within the discourses of the psy-complex itself. Confining ourselves to the UK, self-harm had been a constant presence within the institutional sites of the psy-complex (e.g. accident and emergency departments and psychiatric wards) and within its scientific discourses, with major research centres devoted to its study in the post-1945 period in London,[67] Edinburgh[68] and Oxford.[69]

The second absence denotes what Bhaskar refers to as the 'four-fold polysemy of real negation' - signifying 'absenting' as a historical process rather than a static ontology.[70] Hence the significance of the politics of self-harm emerging from the Bristol Crisis Service for Women (BCSW) in the period 1986-89. This period, in which self-harm, via the activism of BCSW, was for the first time entering a public domain not under the control of the psy-complex, provides a snapshot of the emergence of political activism. It occupies a space between the qualified non-existence of the first absence (1980-86) and the manifest presence of LSH and after (1989-2000). In terms of Bhaskar's four-fold polysemy this occupies an intermediate position between being not-fully-absent yet not-fully-present:

> [a]t the boundary of the space-time region it may be difficult to say whether x is present or absent or neither or both.[71]

In terms of our problem, the boundary to which Bhaskar refers demarcates the periods 1980-86, the first absence, and 1986-89, the second absence, and corresponds to the distinction he draws within his four-fold polysemy between 'process-in-product' and 'product-in-process'.[72] This is a distinction between the constitution of history, including its absences, as a determinate 'given' under the domination of $Power_2$ (process-in-product) and the transformative dialectical praxis of 'absenting absences' of $Power_1$ (product-in-process) which is associated here with social movement activism. Given that $Power_2$ (the psy-complex) in part constitutes the first absence literally through the absenting of survivors autonomous 'voice' - in the post-1945 discourses of the psy-complex the psychiatric 'patient' appears only as an anonymous object of research - it is understandable that, in the absence of a revolutionary crisis, it takes time for the identification and elimination of absences to occur. Although this process was not revolutionary in terms of the politics of self-harm, its presence did appear within a specifiable 'region of space-time': between 1986 and 1989, in England (not elsewhere in the UK), and, given the centrality of BCSW and SSO, within and between Bristol and London.

More now needs to be said about this process of absenting absence. Although the ontological category of absence remains central, for without its existence, its identification and its elimination, there could be no politics of self-harm, the processes by which an absence is transformed into a presence needs to be clarified. This is why Foucault enters the theoretical frame.

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[65] See xxxxxxx 2005, 2016.

[66] D, 43.
[67] Stengel, 1958.
[68] Kreitman, 1977.
[69] URL: http://cebmh.warne.ox.ac.uk/csr/keith.html
[70] D, 39, 105-106.
[71] D, 39.
[72] D, 39, 105-106.

Foucault and the 'process of problematisation'

What, then, were the transformative conditions from which the politics of self-harm emerged? In order to further explain this, we turn to the later work of Foucault who, in a retrospective synopsis, described the emergence of new 'forms of experience'[73] as a 'process of problematisation'. The central passage from the late work is this:

> what I intended to analyse in most of my work was…the process of 'problematisation' - which means: how and why certain things…became a problem. Why…certain forms of behaviour were…classified as 'madness' while other similar forms were completely neglected…Some people have interpreted this type of analysis as a form of 'historical idealism', but I think that such an analysis is completely different. For when I say that I am studying the 'problematisation' of madness…it is not a way of denying the reality of such phenomena. On the contrary, I have tried to show that it was precisely some real existent in the world which was the target of social regulation at a given moment…The problematisation is an 'answer' to a concrete situation which is real.[74]

A problematisation makes a problem of (i.e. it 'probematises') fields of human experience according to the three-fold schema adopted by Foucault in his later work. Fields of experience considered as:

1) Systems of Knowledge;
2) Manifestations of Power*;* and
3) Ethical Codes.[75]

A problematisation ($Power_1$) asks questions of $Power_2$ – but always in the context of 'a concrete situation which is real'. And although the answer which it provides is connected with $Power_2$ - because *that* is what it is problematising - it is also a challenge to its domination and therefore a way of resisting its power. Moreover, a problematisation, for Foucault, is related to the concept of human experience, via his interpretation of the category of 'thought', insofar as a condition for a problematisation is a reflexive movement of thought in which the domination of knowledge, power, and ethical codes are called into question.[76] It is through this movement of thought that 'new forms of experience' emerge. Paul Rabinow has summarised this interpretation of Foucault in this way:

> Foucault's definition of thought as a modern practice is so broad that it comes close to equating thought not only with experience but with action,[77]

but he adds that this does not make thought, experience and action identical, for thought's reflexive potential is precisely that which 'allows one', in Foucault's own words,

> to step back from this way of acting…to present it to oneself as an object of thought and to question it as to its meaning, its conditions, and its goals.[78]

Problematisations in action

In terms of the politics of self-harm, it is possible to identify events from the archives in which a problematisation appears as what Foucault called 'an event of thought'.[79]

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[73] Foucault, 2000a, 200.
[74] Foucault, 2001, 171-172.
[75] See Foucault, 2000a, 262.
[76] Foucault, 2000a, 117.
[77] Rabinow, 2000a, xxxv.
[78] Foucault, 2000a, 117.
[79] Foucault, 2000a, 201.

The Looking at Self-Harm (LSH) conference is the prime example, demonstrating a process-in-product where there was formerly a product-in-process (1986-89). It was upon the platform at LSH that Maggy Ross announced the following problematisation:

> 'I'll tell you what self-injury isn't – and professionals take note...It's rarely a symptom of so-called psychiatric illness. 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'.[80]

Here Ross problematises (Power1) the power of the psy-complex (Power2) primarily as a system of knowledge, offering an alternative definition of self-harm characterised by poetic metaphor (a 'silent scream') rather than positivistic classification ('deliberate self-harm'). But her speech also functions as a problematisation of the power of the psy-complex professional - 'professionals take note'! - and insofar as suicide, self-harm and their inter-relationship form a part of what Bhaskar called 'discursively moralized power2 relations',[81] a challenge also to the psy-complex as an ethical code.

The politics of self-harm (1989-2000) contained many such problematisations, considered as fields of experience in their three-fold form:

1. **Systems of knowledge**. In 1995 the BCSW activist, Lois Arnold, produced one of the first examples of survivor-oriented research based upon survivor and feminist experiences rather than the classifications of the psy-complex and stressing, not a positivistic evidence-base, but one rooted directly in the experiences of women;[82]
2. **Manifestations of power.** Throughout the 1990s Pembroke and the National Self-Harm Network (NSHN) indicted iatrogenic practices within accident and emergency (A&E) departments, including the suturing of wounds without anaesthesia,[83] accompanied by a subsequent call for human 'rights for self-harmers';[84]
3. **Ethical codes.** Between 1998 and the millennium the Action/Consultancy/Training group (ACT) activist Sharon LeFevre[85] problematised the ethical boundaries of the professional-patient relationship by authoring and performing a two-handed drama depicting the interactions between a female self-harmer and her male psychiatrist, featuring her *actual* psychiatrist as the other performer.[86] As that psychiatrist himself, Phil Thomas remarked, such a problematisation of traditional ethical boundaries inaugurated a transformation of the professional-patient relationship such that,

> '[t]he type of staff-patient relationships required to provide a 'person-centred' service are complex. They are neither expert-lay person nor simple friendships'.[87]

Here, then, are examples of problematisations in action – problematisations of, respectively, the positivistic knowledge, iatrogenic powers and ethical codes of the psy-complex. These problematisations are no longer absences although they emerge from absence. And they emerge from absence not in the sense of emerging from 'never anywhere existence' but, rather, as a *process* of emergence, as: 1) process-in-product, as an absence within the discourses of social movements (pre-1986); then 2) product-in-process, as interconnected networks (survivor and feminist) which

[80] Quoted in Pembroke, ed, 1994, 14.
[81] D, 153.
[82] See Arnold, 1995
[83] See Pembroke, ed, 1994.
[84] Pembroke, 1995, 13.
[85] LeFevre et al, 1996.
[86] See James, 2001, 140.
[87] LeFevre et al, 1999, 481.

problematise the power of the psy-complex; finally as 3) a fully present politics of self-harm (1989-2000).

Social Movement Organisations (SMOs) and Interconnected Networks

In this analysis, Foucault's value lies in providing an account of the process of problematisation as a reflexive movement of thought, as an 'event' occurring in human experience. That process identifies individual agents of problematisation (e.g. Ross, Pembroke, LeFevre), locates *when* and *where* problematisations occurred (Bristol, London, Wales), and discloses their *content*. This may sound an arguable claim. After all, Foucault's well-known theoretical mantra, 'where there is power, there is resistance'[88] has been variously critiqued as reified structuralism[89] or, conversely, as voluntarism.[90] Foucault, it is said, simultaneously presumes yet elides the dialectical praxis of freedom upon which, on our reading, problematisations depend. Yet, providing Foucault's account of the process of problematisation is 'preservatively sublated'[91] within Bhaskar's ontology of absence[92] and is supplemented, as we shall see, by an awareness of the sociology of social movements, Foucault takes us part-way to identifying the historical conditions which must be met if an absence is to be transformed into a presence. At this point the individualistic account of problematisations needs to be supplemented by an account of the political processes of social networks and groups - in other words, by an account not of individualistic but collective problematisations. This is why we turn to the sociology of social movements.

Although the individuals identified (LeFevre, Pembroke et al) are indispensable as embodiments of problematisations, that process must not be understood solely in terms of their activism. For what we discover once we return to the archive is that those individuals are precisely the members of interconnected networks and groups - to be more specific, they are members of SMOs (social movement organisations). Social movement theory makes a standard distinction between individual activists, wider social movements (e.g. psychiatric survivor and feminist) and the specific SMOs which collectively embody their aims (e.g. SSO and BCSW).[93] That distinction is useful insofar as it helps us to see how individual problematisations may assume the collective form of Power1 - 'the transformative power intrinsic to the concept of action' - which then enters the 'hermeneutic-hegemonic struggle' with the psy-complex. Chronologically, the SMO memberships of LeFevre, Pembroke et al may be mapped onto the process of problematisation:

1980-86 (process-in-product) - no individual problematisations of self-harm but many survivor and feminist SMOs and individual activists involved in diverse networks of generic activism.[94]

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[88] Foucault, 1990, 95.
[89] Crossley, 2006, 2.
[90] Brown, 1995, 63.
[91] D, 94.
[92] E.g. subsumed within the dialectic of power1 and power2: master-slave relations are 'seldom completely one-sided and always potentially reversible – as in Foucauldian counter-conduct or strategic reversal'. D, 60.
[93] Zald and McCarthy, 1987.
[94] Survivor SMOs: CAPO, SSO; Feminist SMOs: Head On, Women's groups of the GLCWC.

1986-89 (product-in-process) - the beginning of individual problematisations (e.g. Ross) emanating from a single feminist SMO (BCSW) interconnected with individual activists (e.g. Pembroke) from a single Survivor SMO (SSO).
1989-2000 (politics of self-harm) - many individual problematisations (e.g. Arnold, LeFevre, Pembroke) emanating from multiple interconnected SMOs (BCSW, SSO, NSHN, ACT).
It's important to note that the social networks interconnecting individual SMOs are as significant as the SMOs themselves in understanding collective problematisations. They have a particular function in transferring problematisations *between* SMOs, where they augment what social movement scholars refer to as an SMOs 'repertoire of contention'[95] or 'resistance habitus'[96] - the practical forms of dialectical praxis with which they conduct the hermeneutic-hegemonic struggle. In this respect, the key period of Bhaskar's four-fold polysemy is 1986-89 (product-in-process) where one specific cross-fertilisation occurs which culminates in Looking at Self-Harm (LSH). This involves not only two SMOs (BCSW and SSO) but interconnected networks of activists from both (e.g. Ross and Pembroke). In effect the cross-fertilisation of social networks between SMOs provided something new to each SMO:

- To Survivors Speak Out (SSO), it provided a radical feminist frame for understanding self-harm apart from established concerns with forced hospitalisation and treatment. It provided a way of problematising how self-harm and its iatrogenesis disproportionately affected women and, hence, widened the scope of survivor discourse to include not only the psy-complex but institutional patriarchy. In this sense, it reconnected psychiatric survivors with anti-psychiatric feminist activism, often of North American origin,[97] which had been absent within UK survivors.
- To the Bristol Crisis Service for Women (BCSW), it added the psy-complex as a manifestation of Power2 to established indictments of patriarchy. Moreover, it widened the patriarchal frame to include iatrogenesis within the psy-complex and, hence, brought together two discourses of 'survivor' identity: first, the feminist discourse of 'survivors' as victims of sexual violence and childhood abuse which, by 1989, was a major feature of UK and North American activism; second, the 'psychiatric survivor' two-stage identity in which personal trauma is compounded by psy-complex iatrogenesis as in the classic definition of Campbell noted above. The feminist specification of stage 1 of that political identity (personal trauma) added weight to concerns with iatrogenesis (stage 2); whilst the psychiatric survivor specification of stage 2 (iatrogenesis) added weight to feminist concerns with the traumas of patriarchy (stage 1).

But this cross-fertilisation of SSO/BCSW added something else that was radically new. It added what Foucault referred to as a new 'surface of emergence'[98] for political activism within the psy-complex: the Accident and Emergency departments (A&E) of general hospitals. The significance of A&E had been hinted at by BCSW activists in the period 1986-89[99] but became the major feature of the politics of self-harm post-LSH when survivors' experience of A&E was problematised across all three areas of Foucault's schema:

[95] See Alimi, 2015.
[96] See Crossley, 2004.
[97] E.g. Chesler, 1972.
[98] Foucault, 2000b, 40.
[99] Ross, 1988, 45.

1. **Systems of Knowledge**.The risk of suicide and its prediction - and, hence, the connection between suicide and self-harm - had long been a problem for the psy-complex.[100] In A&E that problem presented itself in its 'emergency' form. But from LSH onwards the connection is broken; for survivors the meaning of self-harm can have nothing to do with its predictive status for suicide, but is rather to be understood on its own terms as a survival-mechanism for coping with trauma. In this way, the meaning of self-harm was 'normalised', to be conceived precisely as Pembroke advised, as a 'painful but understandable response to distress…Self-harm is about self-worth, self-preservation, lack of choices and coping with the uncopeable'.[101]
2. **Manifestations of Power.** The question of iatrogenesis now presented itself in an entirely new form. What actually happens to self-harmers in A&E? How are they treated? Before any question of lawful incarceration, the self-harmer is subjected to physical punishment. This is a new indictment at LSH. Punishment took two forms, neither to do with psychiatric treatment, both to do with emergency medicine. The indictment was that emergency medical treatment either as suturing (for self-laceration) or stomach wash-outs (for self-poisoning) was tantamount to 'outright physical abuse',[102] being delivered either with unnecessary force or 'inadequate anaesthesia'[103] to self-harmers. Even seasoned survivor activists found these indictments a shock:

   > 'I found it incredible to listen to individuals talking about their...inwardly directed aggression and then to learn that in accident and emergency departments some of them had been deliberately sutured without the use of anaesthetic.'[104]

3. **Ethical Codes.** Yet iatrogenesis went wider than physical punishment. Indeed, what surrounded such punishment, what to a large extent made it possible, was a specific regime of moralised Power2 relations within A&E. This was unlike anything survivors had encountered before and targeted the self-inflicted nature of the act in 'deliberate self-harm'. What separated the self-harmer in A&E as nowhere else within the psy-complex was the in situ comparison with two other 'emergency' groups: 1) the accident-victim; 2) the 'genuinely' ill, none of whom inflicted 'deliberate' self-harm.[105] Thus, an iatrogenic vocabulary swung into view – the self-harmer was 'manipulative' 'attention-seeking', 'irresponsible'[106] vis-a-vis the other two groups - and this iatrogenesis becomes not only registered in the experience of self-harmers but, for the first time from 1989 onwards, problematised as a manifestation of Power2 within the psy-complex. The politics of self-harm was 'born'.

Absence Explained

To say that the politics of self-harm was 'born' at Looking at Self-Harm (LSH) is to mark its significance as an 'event' - not to suggest that such politics emerged *ex nihilo*. They did not. But this becomes clearer if we summarise answers to the two questions posed:

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[100] See Stengel, 1964.
[101] Pembroke, ed, 1994, 1.
[102] Smith, in Pembroke, ed, 1994, 17.
[103] Pembroke, in Pembroke, ed, 3.
[104] Campbell, 1989, 17.
[105] See Cresswell and Karimova, 2010.
[106] See Diane Harrison, Pembroke, and Smith in Pembroke, ed, 1994; also Cresswell and Karimova, 2010.

Question 1: Why was there an absence of activism before 1986 concerning self-harm?
Question 2: What transformative conditions had to met to turn that absence of activism into the politics of self-harm?
We begin with the second question first.
The main condition that had to be met is clearly the process of problematisation itself. This had individual and collective dimensions. Certainly, individuals matter and problematisations in this dimension are mediated through the individual experiences of self-harmers *before* they become political activists. What unites the individuals significant for the politics of self-harm – Maggy Ross, Louise Pembroke and Sharon LeFevre in particular – is that they all had what Pembroke called 'direct experience'[107] of self-harm. In other words, they had experienced both self-harm and iatrogenesis. Later, they became members of SMOs and collectively problematised this iatrogenesis. We don't say that all activists must have 'direct experience' of iatrogenesis, but to the extent that individuals do matter, some of them must. Nevertheless, direct experience still had to be transformed into a collective problematisation via SMOs and interconnected networks to emerge as a politics of self-harm.
The process of problematisation is just that - a historical process. Bhaskar's four-fold polysemy helps us to see that an absence is absented only *in* time. The four-fold polysemy is specific and contingent. The specificity is that two generic struggles – survivor and feminist – coalesced via two SMOs (Survivors Speak Out [SSO]) and the Bristol Crisis Service for Women [BCSW]), to emerge as a politics of self-harm. This emergence was also spatio-temporally specific; it occurred between 1986 and 1989 (product-in-process) within and between Bristol and London. The problematisation of iatrogenesis within Accident and Emergency departments within this time period and these locations was the most precise and contingent condition.
Why, though, the absence of activism before 1986? There is a tautological and a substantive response. Tautologically, there was no politics of harm because there had been no process of problematisation. And there had been no problematisation because there had been neither individual problematisers nor problematising SMOs: neither individual nor collective problematisations. But the formalism of this tautology alone provides neither empirical nor theoretical answers.
The substantive question is this: why were there no problematisers? After all, if individuals matter, then we can hardly claim that there were no individual experiences of iatrogenesis in A&E before 1986; that no-one had been physically punished or subjected to the ethical codes of emergency medicine. On the contrary, because self-harm was present external to survivor and feminist discourse within the main institutional sites of the psy-complex in the post-1945 period, it is safe to say that many hundreds of individuals had personally had those experiences. But for the individual experience of harm to be constructed as iatrogenesis there had to be collective problematisations and it is this that was absent in the pre-1986 period. Why? Again, the answer is spatio-temporally specific.
The two social movements involved were the psychiatric survivor and feminist movements. They had similar historical trajectories in terms of self-harm although the details differ. Psychiatric survivors only became 'survivors' as such in 1986 with the formation of Survivors Speak Out (SSO); before that they had been known as the 'mental patients movement' and their chief SMOs had been the Protection of the

[107] Pembroke, in Pembroke, ed, 1994, 3-4.

Rights of Mental Patients in Therapy (PROMPT) and the Campaign Against Psychiatric Oppression (CAPO). The new discourse of 'survivors' developed alongside the transformation from an 'asylum' system of hospitalised care to 'care in the community'. Before 1986, the main aspects of iatrogenesis which concerned PROMPT and CAPO were those of lawful incarceration and forced treatment in psychiatric hospitals. The advent of SSO heralded a wider range of concerns which in the decade to come included self-harm, 'eating distress'[108] and 'hearing voices'.[109] These resisted specific diagnostic categories of the psy-complex: 'deliberate self-harm', 'anorexia' and 'schizophrenia' respectively, rather than being concerned solely with incarceration. And because two of them, self-harm and eating distress, disproportionately affected women, they brought psychiatric survivors into contact with feminism in a way that had not happened before in the UK. Before these interconnections (1986-89), any discourse upon self-harm was absent and could not be subjected to the process of problematisation

Feminism, similarly, had 'ignored' self-harm. It did not appear in the 'bible' of feminist health activism *Our Bodies, Our Selves*, first published in 1971,[110] until it was indexed in the edition of 1989.[111] It was also absent from the main journals of feminist activism, *Spare Rib* and *Trouble & Strife*, throughout the 1980s.[112] Why? Tamsin Wilton said as late as 1995 that self-harm was 'almost entirely absent from feminist literature on women's health'.[113] We can speculate why this absence was so: perhaps in the same way that it was 'punished' in A&E, it was absent within feminism – its self-inflicted nature made it too 'inconvenient' a fact. Feminism was used to resisting patriarchal abuses and in this sense the discourse of 'survivor' identity within feminism pre-dates that of 'psychiatric survivors' by up to a decade.[114] But these were abuses perpetrated upon women's bodies by men (domestic violence, sexual abuse etc.) - not violence inflicted upon women's bodies by themselves. For these reasons neither feminism nor survivors alone had resisted self-harm's iatrogenesis within the psy-complex; nor had they spoken about it at all before 1986. It was absent. It took the interconnected networks of feminists and survivors working together to problematise iatrogenesis and, subsequently, to give the politics of self-harm its 'birth'.

[108] See Pembroke, ed, 1992
[109] See James, 2001, 50.
[110] Boston Women's Health Collective, 1971.
[111] Boston Women's Health Collective, 1989.
[112] These were consulted in the Feminist Archive North (FAN).
[113] Wilton, 1995, 36.
[114] See Herman, 1981.

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