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Self-Harm and Medicine's Moral Code: A Historical Perspective, 1950–2000

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"Deliberate self-harm"—acts of self-poisoning (overdosing) or self-injury (e.g., cutting) that do not result in death—has historically provoked a moral judgment in those professionals who treat it. Such judgments negatively value the act of self-harm and lead to the discriminatory treatment of self-harmers in accident and emergency departments and upon psychiatric wards. This article argues that the treatment of self-harmers in such environments has its origins in a "moral code" that negatively values the act of self-harm in comparison to (a) suicide, (b) the accident victim, and (c) individuals considered to be "genuinely" physically ill. The article fulfills two functions. First, it tracks the history of "medicine's moral code" as it surrounds self-harm in the British context during the period 1950–2000. Then it turns to examine the ways in which patients groups—so-called psychiatric survivors—resisted such discriminatory treatment in the period 1988–2000. Such resistance, the article concludes, creates the opportunity for a democratic dialogue to develop between patient groups and service providers that could potentially ameliorate the deleterious effects of medicine's moral code. The article's tone is polemical and is expressly written from a perspective sympathetic to the political claims of "survivors," which the authors conclude forms a central component in the development of democratic practices within medicine and psychiatry.

[AuQ1] **Keywords:**

"Self-harm"—or, as psychiatrists call it, "deliberate self-harm" (DSH)—has historically provoked a *moral judgment* in those professionals who "treat" it. It is as if acts of self-poisoning (overdosing) or self-injury (e.g., cutting) evoke a judgment from professionals that is different from other self-injurious acts such as smoking or drinking. The first question we wish to ask, then, in this article, is this: *what* is that judgment?

Comparisons are significant here, for when, in 1988, Dr. Gillian Mezey, a psychiatrist at London's Maudsley hospital, was interviewed by the *Guardian* about self-harm, she had this to say:

> It [self-harm] makes staff feel uncomfortable. The controversy is whether or not you respond to their needs by giving them [self-harmers] what they want . . . it may encourage them to do it again. . . . Psychiatrists are not uncaring but they feel the same *revulsion* as anyone else and have the same difficulties dealing with their feelings. (Hanson, 1988, p. 17, emphasis added)

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Surprisingly, Mezey describes her feelings as "revulsion," which the dictionary defines as a "sudden violent change of feeling, a strong reaction." Yet psychiatrists are, after all, medical people; they treat many examples of suffering during the course of their work, but they do not usually describe their reactions to these as "revulsion." So, the second question we want to ask concerns the *meaning* of Mezey's "revulsion." a meaning that, far from being unusual, is, she insists, "the *same*…as *anyone* else" (Hanson, 1988, p. 17, emphasis added).

To regard the act of self-harm with "revulsion" is a *moral judgment*. And this implies that, where self-harm is concerned, professionals respond with an *attitude* that may be understood by means of that well-known expression "weighing it up." In other words, professionals impose on self-harm a judgment of *negative value;* they "weigh it up" according to a moral scale and find it "wanting." This is why comparisons are significant, for the professional attitude that negatively values self-harm is one that is largely absent with regard to smoking and drinking and *wholly* absent in, say, the accident and emergency department's (A&E) reaction to the accident victim.

This article's first task is to show how such "strong reactions" and moral judgment combine to produce, with regard to self-harm, what we call "medicine's moral code." *Medicine's moral code represents a complex of attitudes and practices in the context of which professionals "treat" self-harm*. It is, as it were, the professional "ideology" that lies behind the treatment of self-harm and provides its justification.

The article's second task is to expose medicine's moral code as a *discriminatory* code. Professionals' treatment of self-harm *discriminates* against self-harmers, creating adverse effects in their lives. Self-harmers suffer not only through past traumas and the act of self-harm but also through direct contact with those service providers (A&E/psychiatry) that police the code. Such services categorize self-harmers, employing a discriminatory vocabulary ("attention seeking," "manipulative," "irresponsible," and so on) that, as Judith Herman (1992) remarks, amounts to little more than a professional "insult" (p. 123).

The history of the code displays a division: it goes largely uncontested in the post–World War II period in Britain, which closes by 1988. After that, it comes under increasing attack. Specifically, it comes under attack from "psychiatric survivors" (i.e., groups of self-harmers themselves) who confront it with an alternative code of their own. This alternative code has since become known, following survivors' activism (see National Self-Harm Network [NSHN], 1998, 2000), as "harm minimization."

The article's tone is polemical and normative, by which we mean that it refers to medicine's moral code in terms of self-harm as a discriminatory code in alliance with a perspective adopted by psychiatric survivors since the mid-1980s and expressed since that time in various forms (e.g., Pembroke, 1994; Shaw, 2005). In this respect, it continues the authors' sociological work on psychiatric survivors in accordance with what has been previously called a "politico-ethical stance" (see Cresswell & Spandler, 2009, p. 143)—a stance that is politically engaged and works from *within* a survivor perspective (see also Church, 1996).

MORAL VALUE AND HUMAN BEHAVIOR

A theoretical note before we proceed. This article often refers to the terms "moral" and "value" and to the latter as being either "positive" or "negative." It is worth clarifying the

employment of these. "Moral" and "value" go together because in "weighing up" aspects of human behavior, we usually ascribe to them a "value," not in the sense of a numerical value but in the sense that we consider behavior praiseworthy or blameworthy, we tolerate or we condemn it, or we even experience "revulsion." When we consider behavior blameworthy or condemn it, we make a judgment of "negative value." Indeed, we argue that such judgments and the practice of "discrimination" are tightly entwined. The central argument advanced here is that this is the way that many professionals have regarded self-harm.

There is a significant point to add, however. At the heart of our argument is the idea that we tend to morally value behavior *in comparison with other specific behaviors*. This is why we have been quick to state that "comparisons are significant" and have compared self-harm already with other behaviors, such as smoking, drinking, and being an accident victim. In other words, when we say that self-harm is "negatively valued," we mean that it is condemned *in comparison with other behaviors, which are positively valued in comparison with self-harm*.

Three such comparisons are thematic in this article: the comparisons of self-harm with (a) suicide, (b) the accident victim, and (c) the "genuinely" ill. Such comparisons, together with the moral values that surround them, have facilitated the formation of medicine's moral code in the post–World War II period and have particular significance in medical settings, especially, as this article shows, in the A&E department and the psychiatric ward.

The article is divided into two parts. First, we chart the code's formation from 1950 to 1988, noting its expressions in medical, legal, and sociological fields. We then examine the ways in which "psychiatric survivors" have resisted the code, particularly the practice of "harm minimization."

SELF-HARM AND MEDICINE'S MORAL CODE, 1950–1988

Although resistance to medicine's moral code is confined to the activism of the "psychiatric survivor" movement from the mid-1980s on, it is possible to detect criticisms of it prior to that. This section sketches three such manifestations, providing a context within which to understand both the code itself and the later activism of survivors. These manifestations are the following:

1. Psychiatric expertise, specifically the work of Erwin Stengel (1958, 1964) with Cook, the first researcher to give sustained attention to self-harm without *presuming* that it was necessarily a *suicidal* act. The comparison between suicide and self-harm goes to the heart of the code.
2. Statute law, especially debates surrounding the Suicide Act of 1961, which for the first time in England and Wales decriminalized suicide and its "attempt." The significance of this is that self-harm became increasingly connected (post-1961) to the field of medicine rather than to that of the law.
3. Sociological research, particularly that of Roger Jeffery (1979), which foreshadowed arguments against the code that psychiatric survivors later advance. These arguments extend the comparative analysis surrounding self-harming behaviors to include not suicide only but also (a) being an accident victim and (b) the perceptions of health care professionals about what it means to be "genuinely" ill.

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Erwin Stengel and the Distinction Between Self-Harm and Suicide

The psychiatrist Erwin Stengel conducted research into suicide and self-harm in the post–World War II period. He proceeded from a simple premise: while volumes of research existed on the subject of those who died from self-injurious acts (suicide), there was a dearth of research about those who had survived them. Today, the need for such research seems obvious, but in the 1950s Stengel's was an original voice in advancing the following perspective: "It almost seems as if the essential difference between suicide and attempted suicide had been overlooked, i.e. that the person who has attempted suicide lives on . . . and that the attempt becomes a significant event in his life" (Stengel & Cook, 1958, p. 119).

To remedy this situation, Stengel did, in fact, research nonfatal self-harm, and he did so by employing the simple method of identifying admissions to hospital of individuals following episodes of self-harm and then interviewing them afterward. Stengel's findings shed light on the code in the following ways. Although a small proportion of self-harmers did indeed go onto commit suicide, the majority did not. Self-harmers, Stengel concluded, should be regarded as a distinct "population" from suicides. From this, it followed that in the majority of cases of self-harm, death was *not* the intention. Obviously, these points combined pose this question: what was the intention? Stengel's view was clear: in the absence of a death-directed intention, the act of self-harm should be understood as a "social behavior pattern" (Stengel & Cook, 1958, pp. 114–121). It displayed what he termed an "appeal function" that could not be understood without reference to the "social field" within which self-harm occurred. This social field included friends and family but also, significantly, the "hospital environment" (see also Farberow & Schneidman, 1961).

Stengel's point was to differentiate self-harm from suicide by noting that not only is its motivation not death but is, in fact, its opposite: "*survival* appears at least as . . . legitimate an outcome as death, and it becomes clear that it is erroneous to divide suicidal acts . . . death being the only criterion of success" (Stengel & Cook, 1958, p. 115, emphasis added).

Stengel was fully aware that his "discovery"—the distinction of self-harm and suicide—was not the accepted view. Indeed, his achievement was to expose the fact that in both the public and the professional perception, a *moral judgment* surrounded self-harm. What characterized this judgment was that it perceived self-harm *in comparison with suicide only* and had yet to understand it as a separate act. In terms of the public perception, Stengel commented,

> The survivor of a suicidal attempt is regarded . . . as having either bungled his suicide or not being *sincere* in his suicidal intention. . . . It is taken for granted that the sole aim of the *genuine* attempt is self-destruction and therefore the dead are successful and the survivors unsuccessful. (Stengel & Cook, 1958, p. 19, emphasis added)

Note the *moral* judgment that lies behind the emphasized words. Stengel pinpointed how, if death alone is to be considered the criterion of "success," then the surviving self-harmer tends to be seen as somehow morally lacking—as *in*sincere or *un*genuine in comparison to suicide. It is a short step from this judgment to conclude that the self-harmer, in performing the act, harbors ulterior motives of a morally dubious kind. Stengel revealed how

the professional perception of self-harm speculates in discriminatory fashion about what these "ulterior motives" could be, quoting the work of contemporaries Lewis Siegal and Jacob Friedman. "Suicidal threats," Siegal and Friedman remarked, "pervade our entire social structure . . . the threat of suicide forces people to marry, prevents marriage dissolution . . . forces parents to acquiesce in their offspring's vicious habits . . . etc." (Stengel & Cook, 1958, p. 119). To these sentiments, Stengel responded, "The authors, by their unsympathetic attitude . . . demonstrate that they share the popular belief that an *honest*, i.e. a *genuine*, suicidal threat . . . has to be dominated by the purpose of self-destruction" (p. 119, emphasis added).

Here we find a first criticism of the code. Stengel revealed how the act of weighing up self-harm always takes place with the comparison of a "successful" suicide *already* in mind. According to this perspective, if suicide is the *genuine* article, self-harm must be some sort of "fake." Because of this, the self-harmer is perceived as having not so much "bungled" her suicide as, rather, having been insincere in her intention in the first place, in other words, as possessing ulterior motives. The act of self-harm thus becomes synonymous with a morally negative vocabulary such as *un*genuine, *dis*honest, and so on.

Finally, Stengel exposed the "unsympathetic" attitude of professionals by showing how they weighed up those ulterior motives in a discriminatory fashion. Where Stengel detected an "appeal" for human compassion, Siegal and Friedman weighed up those ulterior motives as deliberate attempts to manipulate the environment to the benefit of the self-harmer. And it was the morally negative adjectives that accompanied this view—insincere, ungenuine, dishonest, manipulative, and so forth—that were to become a constant feature of the professional vocabulary of self-harm for some time to come.

The Suicide Act of 1961

Stengel deserves further credit for his legal campaigning in the years prior to the passage of the Suicide Act of 1961. Before that date, suicide and its "attempt" had been considered an "offense" in both juridical and religious terms, punishable in ways that would be considered barbaric today (see St. John-Stevas, 1961). In effect, this meant that surviving self-harmers, insofar as they were deemed to have "attempted suicide," could be liable to a period of *imprisonment*. However, with the rise of the medical professions, from the 19th century on, a sea change occurred in attitudes to suicide and self-harm that became increasingly regarded as *medical* rather than *juridical* problems. Because of this, a powerful lobby formed comprising the British Medical Association and the Magistrates Association (see British Medical Journal Supplement, 1947), later joined by the Church of England (see Church of England Board for Social Responsibility, 1959), which campaigned for reform of the law. This was duly enshrined in the Suicide Act, which momentously declared, "The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated" (Suicide Act of 1961).

[AuQ2]

A year later, Stengel observed how this recategorization of "attempted suicide"—from a juridical to a medical problem—was swiftly implemented:

[AuQ3]

> The Ministry of Health . . . followed up the passage of the *Suicide Act* with a circular to hospitals, medical practitioners and local authorities "to see that all cases of attempted suicide which come to their notice," receive adequate *psychiatric* care. *Attempted suicide is in future to be regarded as entirely a medical and social problem*. (Stengel, 1962, p. 204, emphasis added)

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Like Stengel, we should consider the Suicide Act an example of progressive legislation. Yet we need to look beyond this to its significance for medicine's moral code. To do so is to uncover the following:

1. Despite the fact that the act decriminalized suicide and abolished legal punishment for the surviving self-harmer, it nevertheless reinforced the comparison *between self-harm and suicide*. Contributors to parliamentary debates prior to the passage of the act were insistent on this point: "The real basis of the measure is that in the humane outlook of today it is recognised that *those who attempt suicide unsuccessfully* are in need of compassion . . . not punishment" (Hansard, 1962a, p. 837, emphasis added). [AuQ4]
2. Yet, like Siegal and Friedman before them, both houses of Parliament also suspected *some* self-harmers of ulterior motives. In the debates of 1961, members of Parliament (MPs) and peers began to refer to a "gap group"—a group of people who, like Siegal and Friedman's "suicidal threats," were considered "*un*genuine": "Among these [the "gap group"] are those who may not seriously intend to commit suicide but may want to *make a nuisance of themselves*" (Hansard, 1962b, p. 274, emphasis added). [AuQ5]

The problem posed by the "gap group" concerned the issue of their "disposal." What was to be done with them? The Suicide Act rejected the option of "disposal" via the criminal justice system. For those considered "genuinely" suicidal, an answer was readily found: they would either be so physically injured as to require general hospitalization or else considered to be "suffering from a mental disorder" (Hansard, 1961b, p. 250) and [AuQ6] therefore liable to "detention for 28 days observation" (Hansard, 1961b, p. 250) under the provisions of the Mental Health Act of 1959. But the situation was not nearly so clear-cut for the gap group. One MP referred to this as the problem of the "people who do not fit" (Hansard, 1961b, p. 1419), and proposals to get them to "fit" included one or more of the following:

- Placing them "on probation"
- A guardianship order on the model of the Children's and Young Persons Act of 1933
- Imploring "them" (self-harmers) to take "responsibility" for their actions

It is true that the government of the day considered none of these solutions practicable, arguing instead that the gap group constituted only a "small minority" of self-harmers. However, a subsequent Ministry of Health inquiry (Central Health Services Council, 1968)—the "Hill" Report—into "Hospital Treatment of Acute Poisoning" noted that the "incidence of self-poisoning is now of "epidemic" proportions" (p. 19) and could by no means be dealt with by "disposals" of a purely medical kind. The Hill Report concluded that the question of "disposal" needed to take into account not only those considered "genuinely" suicidal but *also* the gap group, not just "in-patient psychiatric care" (p. 20) but also "ongoing . . . social supervision" (p. 20). Clearly, the government's theory that the gap group was a "small minority" was noticeably wide of the mark.

The Suicide Act and the debates surrounding it develop our knowledge of the code significantly. Although self-harm was certainly *decriminalized* in 1961, this is not the same as saying it became less of a *moral* problem. On the contrary, as Stengel noted, self-harm was *already* incorporated into codes of public and professional morality as much as it was in the criminal law. As the Ministry of Health was quick to point out, self-harm was now a "medical and social," no longer a "criminal," problem. What we witness with regard

to self-harm is, therefore, not the disappearance of the moral code that surrounds it but, rather, the *medicalization* of that code.

For this reason, we must temper our opinion of the "progressiveness" of the act. Perhaps it is preferable to be medicalized rather than criminalized, to be "disposed of" in the psychiatric ward rather than the prison cell. But to this we must add qualifications. To repeat, from the Suicide Act on, the moral code surrounding self-harm is *entirely* a medical one; its fields of application will be medicine and psychiatry. This means that the moral judgment surrounding self-harm will no longer be personified by policeman and magistrate, no longer embodied in prison and court; from this moment on, the A&E nurse and the psychiatrist will police the code. Shall we say that such influences are purely "progressive," or shall we say, rather, that they expose self-harm to a code of a different kind that, if it does not "punish" in quite the same way, may nevertheless remain quick to judge and condemn? In any case, we can now inventory a *medical* moral vocabulary of negative value: the self-harmer is "insincere," "ungenuine," "manipulative," "irresponsible," a "nuisance," and so on.

Hence, despite Stengel's "discovery," the importance that must still be attached to the self-harm–suicide link. True, Stengel had correctly stressed their difference: suicides and self-harmers are distinct "populations." But this observation holds for the psychiatrist in his role as a scientist, not in his practice as a *moralist*. For Siegal and Friedman, as much as for MPs and peers of the realm, it was always for its moral value that self-harm was weighed up. And if, on one side of the scale, there is a vocabulary of negative value—"insincere," "a nuisance," and so on—*all* of which is attached to self-harm, this vocabulary really gains its meaning only by comparison with the positive values amassed on the *other* side of the scale. That vocabulary of positive value—"genuine," "sincere," and so on—is attached *only* to suicide. This is why if we confine ourselves to the "scientific" study of self-harm and neglect the moral values surrounding the self-harm–suicide link, we will not strike at the heart of the code.

Roger Jeffery and the Self-Harmer as "Rubbish"

In any case, though Eric Fletcher, MP, had said of self-harmers that "they are in need of compassion . . . not punishment" (Hansard, 1962a, p. 837), we should not automatically conclude that "punishment," which is part and parcel of criminal law, is absent from medical practice. This is the conclusion to be drawn from the work of Roger Jeffery, a sociologist who studied the treatment of self-harmers in A&E departments in the 1970s. Jeffery's (1979) study, "Normal Rubbish: Deviant Patients in Casualty Departments," enhances the analysis offered so far by providing insights into the treatment of self-harmers in A&E. Jeffery's method was direct: he physically observed medical practice in a number of A&E departments and conducted interviews with the doctors and nurses working there. The results were startling.

First, Jeffery (1979) endorsed the significance of the self-harm–suicide link for the code, noting the comparison that A&E staff drew "between those who really tried to commit suicide (*for whom there is some respect*) and the rest (*viewed as immature calls for attention*)" (p. 100, emphasis added), the latter being associated with what we have referred to as the gap group. However, Jeffery also modified our understanding of the self-harm–suicide link by incorporating it into a *wider* comparison that is both a moral *and* a medical one. This comparison is not concerned solely with the question of what it means to be "genuinely"

suicidal; it is also concerned with the question of what it means to be "genuinely" *ill*. This question is relevant for A&E staff because, unlike other medical specialties, they are obliged to treat "a great variety of patients who present themselves" (Jeffery, 1979, p. 91) at their door. Faced with such variety, Jeffery observed how A&E staff responded by categorizing such patients into two groups: either they were "good patients," or else they were "rubbish" (Jeffery, 1979, pp. 91–103).

This categorization answers to the following question: what does it take to be counted as ill? Jeffery's answer was that the "good patients"—"head injuries," "cardiac arrests," "road traffic accidents" (Jeffery, 1979, p. 92), and the "genuinely" suicidal (pp. 100, 102)—satisfied a number of unwritten "rules" that needed to be followed if a patient wants to be "counted as ill." These rules included the following:

- Not being "responsible" for the presenting "illness" (pp. 99–101)
- Cooperating with staff (pp. 101–103)
- Wanting to "get better" (p. 101)

Just as we noted how the vocabulary of negative value ("insincere," a "nuisance," and so on) surrounding self-harm gains its meaning by comparison with the positive vocabulary of suicide ("genuine," "sincere," and so on), so the positive vocabulary of "genuine illness" ("cooperative" and so on) gains *its* meaning by comparison with the negative vocabulary of "rubbish." But who is being classified as "rubbish?" Jeffery is clear that "rubbish" includes the self-harmer and that what characterizes such patients is that they fail to obey those unwritten "rules." So, whereas the accident victim is regarded as "not responsible" for incurring an injury, the self-harmer, by contrast, "knew what they were doing and chose to take an overdose for their own purposes" (p. 100).

Similarly, whereas the "cardiac arrest" wants to "get better," self-harmers "are seen to want to be ill in order to put moral pressure on someone" (Jeffery, 1979, p. 101). Finally, instead of actively cooperating with treatment, "overdoses fight back when a rubber tube is…*forced down their throats* so that their stomachs can be washed out" (pp. 101–102, emphasis added).

Second, the latter example raises again the issue of "punishment." Clearly, to have a rubber tube "forced down" one's throat and "being held down and sat upon" (Jeffery, 1979, p. 103) during the course of that "treatment" would amount, in a nonmedical setting, to a form of assault. Jeffery correctly called this "punishment" (pp. 103–104) and explained it in terms of the "frustration" staff felt faced with patients who resisted the "rules" (p. 100). "Rubbish" patients, Jeffery remarked, were "liable to punishment" (p. 104), and this consisted of both "verbal hostility" and physical "restraint" (p. 103). Criminal "punishment," it seemed, had not, as Eric Fletcher had hoped, been replaced with medical "compassion" by the Suicide Act. Rather, the medicalization of the code surrounding self-harm remained compatible with "punishment" but of a specifically medical kind.

Jeffery wrote in 1979 at a time when, although there was some awareness of the code, there was no collective resistance to it by patients themselves. By "collective resistance," we are referring to the type of political activism associated with "protest movements," such as feminism, gay liberation, black power, and antipsychiatry (see Crossley, 2002). Such movements fought against their oppression and for their human rights; they sought a "voice" where previously they had been silenced. But in 1979, the "voice" of the self-harmer had yet to be heard. However critical his stance, it is worth recalling that Jeffery

had interviewed *only* the staff in A&E, *not* the patients. Similarly, though Stengel did interview patients, he saw himself primarily as an "expert" on *their* experience, not the patients' "ally." But the time was approaching when self-harmers would start to speak for their *own* experience and *resist* medicine's moral code. It is to that "resistance" that we turn in the second half of this article.

PSYCHIATRIC SURVIVORS AND HARM MINIMIZATION, 1988–2000

The rise of the psychiatric survivor movement has been depicted elsewhere, and there is no space to repeat it here (see Crossley, 2006; Cresswell, 2005a, 2005b, 2007). Self-harm survivors, as a subset of the psychiatric survivor movement, make up a network of individual activists and groups who have committed acts of self-harm that have brought them into contact with medical services. Self-harm survivors have protested about the "treatment" they have received and have tried to reform services to make them more sensitive to their life experiences, including their actual experiences of using those services (see Pembroke, 1994). The previous section on the development of medicine's moral code in the post–World War II period historically supports the validity of the survivor perspective.

The self-harm survivor movement has its roots in a combination of mental health and feminist activism, which flowered in England in the mid- to late 1980s and was particularly concerned to raise awareness about women's experience of sexism, self-harm, and service provision (see Harrison, 1995; Ross, 1988). However, activists were also aware of and spoke out about men's experience of self-harm and their "treatment" (see Smith, as cited in Pembroke, 1994, p. 18; Dace & Smith, 1998).

The movement achieved some important historical milestones in this period:

- The establishment of the Bristol Crisis Service for Women (BCSW) in 1988, the *first* campaigning organization to raise social awareness about the needs and "treatment" of self-harmers (see Wilton, 1995)
- The "Looking at Self-Harm" conference of 1989, the *first* event ever held on self-harm that was entirely organized by the survivor movement (Asylum, 1989, p. 16), bringing together key activists from BCSW with "psychiatric survivors" from the London-based organization "Survivors Speak Out"
- The formation of the NSHN in 1995, the *first* national campaigning body focused upon self-harm and led by "survivors" (see Pembroke, 1995)

These achievements *are* milestones; they transform our understanding of medicine's moral code in the latter part of the 20th century. What is only hinted at in Stengel and Jeffery becomes fully exposed in the work of survivors. If Stengel and Jeffery provide clues to detect the code, survivors also demand that its discriminatory effects be addressed. At the same time, survivors' own suggestions for alternative practices (e.g., harm minimization) remain of significance today.

Consider, for example, the issue of "punishment." Jeffery had certainly observed this, if somewhat dispassionately. The speeches at the "Looking at Self-Harm" conference, by contrast, were far more explicit. Andy Smith referred to "outright physical abuse" (in Pembroke, 1994, p. 17) suffered in A&E in the form of "inadequate anesthesia" during

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the stitching of self-inflicted wounds. Louise Pembroke (1994) called such treatment "common" (p. 3) and, echoing Jeffery's observations, but this time from personal experience, testified to the punishments meted out for self-poisoning too:

> She [a nurse]…informed me that I would be given a "Gastric Lavage."…Several pairs of hands pinned me to the trolley whilst the treatment was carried out….As the doctor took blood I screamed. (p. 32)

Yet it would be wrong to regard punishment alone as defining the code. For what made such practices possible, what provides for their ongoing justification, is a discriminatory attitude expressed in a vocabulary of negative value, which weighs up self-harm. This vocabulary arises because self-harm is negatively valued *in comparison with* the "genuinely suicidal" (Stengel), the "genuinely ill" (Jeffery), or, in the overall sense of the "good patient" (Jeffery), both. All this survivors surmised from their direct experience of "treatment."

The remainder of the article tracks survivor activism as it relates to the attributes—punishments, attitudes, vocabularies—that make up the code. This will complete the tasks set out at the article's start and, further, will show that such activism leads not just to criticisms of the code, in the style of Stengel and Jeffery, but also to a *reevaluation* of self-harm itself. Self-harm, survivors will show, is possessed of *positive* value.

Suicide

Survivors appeared to endorse Stengel's distinction between self-harm and suicide. As Louise Pembroke (1994) observed, "There are two distinct types of self-harm: Firstly, self-harm with suicidal intent….Secondly, self-harm without suicidal intent" (p. 2).

But in this they owed Stengel no debt. In fact, survivors' radicalism may be defined not only in terms of a *distinction* to be drawn between self-harm and suicide but also in terms of a *connection*. Stengel saw the two as distinct populations, useful for purposes of scientific research; he always conceded that *some* self-harmers *might* go onto commit suicide, and he was interested in such questions as "Who?" and "Why?" In that sense, though the majority of self-harmers do not commit suicide, self-harm could be considered what today would be called a "risk factor." For Stengel, this was a *scientific* issue concerning questions of cause and effect and in no way detracted from his opinion that it was clinically wrong to negatively value self-harm in comparison to suicide in the manner of, say, Siegal and Friedman.

Stengel's opinion remains valid as a criticism of the code. But survivors went further than this. They saw that *discrimination* produced *by* the code could have such devastating effects on the survivor that the code itself, rather than self-harm, was a risk factor for suicide. This effect of the code has often been noted: "It is poor responses from mental health service and A&E that culminate in such loss of self-worth that people are *driven to commit suicide*" (Pembroke, 2002a, p. 18, emphasis added; see also Diane Harrison, in Pembroke, 1994, p. 7).

This constituted a more radical challenge to the code than Stengel's criticisms. For, when the code negatively valued self-harm in comparison with suicide, survivors responded by *inserting* the code as an intermediary between the self-harm–suicide link—as *itself* a risk factor for suicide. The connection is profound and, in a sense, identifies the ultimate punishment deployed by the code. It is a connection all too tragically derived from experience itself.

And it was "from experience itself" that survivors arrived at a focus on "self-harm without suicidal intent" (Pembroke, 1994, p. 2). This took the distinction between self-harm and suicide as established apart from the radical challenge sketched out previously. Generally, survivors were as concerned with resisting the comparison with the wider category of the "good patient" that negatively valued them and was such a discriminatory feature of service provision.

The "Good Patient"

The key to understanding this comparison is the very idea of *deliberateness* at the heart of the category "deliberate self-harm" (DSH). The adjective "deliberate" in DSH is one that survivors resisted. Louise Pembroke (1994) expressed it like this: "Self-harm . . . does not require qualifying with 'Deliberate'" (p. 3).

Why not? There are two reasons and they strike at the heart of the code.

First, because, as psychiatrists would surely admit, the point of the "deliberate" in "*deliberate* self-harm" is precisely to establish a *comparison* between the self-harmer and accident victim—to the former's detriment. This is apparent even from medical definitions, such as that of Gethin Morgan (1979), who coined the term (DSH) as "a *deliberate* non-fatal act, whether physical . . . or poisoning, done in the *knowledge* that it was potentially harmful" (p. 88, emphasis added).

That sounds "objective"—until it is inserted into the negative vocabulary of the code. As Jeffery (1979) observed, "rubbish" is compared with the "good patient" exactly to the extent that the self-harmer had prior "knowledge" of the harm they would cause: "[the self-harmer] *knew* what they were doing and chose to take an overdose for their own purposes" (p. 100, emphasis added).

The discriminatory effects of the use of "deliberateness" have been inventoried by survivors. Diane Harrison, a founder member of BCSW, observed, "I cut my throat and had to go into hospital. The nurses were really kind to me *until they found out that my injury was self-inflicted*" (in Ross, 1988, p. 45, emphasis added). In "Looking at Self-Harm," Andy Smith pinpointed the consequences of being treated as someone who, in knowing "what they were doing," had failed to "play the game" by the "rules":

> The staff attitude . . . was one of deterrence. . . . "The element of humiliation could consist of being told that any discomfort I might be feeling from the festering week old wound . . . was invalid *because there were people there who were injured by accident*." (Smith, as cited in Pembroke, 1994, p. 17, emphasis added)

Second, because the notion of DSH, divorced from Morgan's medical definition, has a *wider* meaning than medicine itself allows. Here we witness an important innovation of "self-harm survivors": to have not only resisted the definition DSH, in its narrow medical sense, but to have *expanded* it in the wider sense of *a continuum of nonfatal self-harming behaviors*. This expansion has elsewhere been called *the continuum concept* (see Cresswell, 2005a).

What is this "continuum?" At the heart of medicine's moral code are discriminatory practices that *de*value self-harm in relation to comparatively valued behaviors: suicide, accident, and illness. The code *isolates* DSH and surrounds it with negative value. The thrust of survivors "continuum concept" is to resist this isolation and stress, instead, the *common-ground* shared by nonfatal self-harming behaviors. Obviously, this

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common ground does not include suicide, but it does include a wider range of self-harm than DSH permits. This continuum includes behaviors that are already captured by medical categories, as Maggy Ross of BCSW described at "Looking at Self-Harm": "*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 and scalding oneself, or swallowing non-ingestants like bleach" (in Pembroke, 1994, p. 14, emphasis added).

At first sight, establishing the continuum like this may *not* seem to resist the discriminatory effects of the code; after all, do not anorexia, drug and alcohol abuse, and so on fall victim to moral codes of their own—codes that share certain features with that surrounding self-harm? Jeffery (1979), recall, noted that self-harmers were classified not only as "rubbish" in A&E but as "tramps" and "drunks" as well (pp. 96–98). However, the continuum proposed by survivors stretches wider than this, for it includes not only what Tamsin Wilton—also of BCSW—called "not socially acceptable" acts of self-harm (e.g., Maggy Ross's list) but "socially acceptable" acts as well (see Wilton, 1995, p. 36; see also Pembroke, 1994, p. 2). The list of the latter, as Louise Pembroke noted, is large, including the following:

- Liposuction
- Bikini-line waxing
- Wearing high heels
- Dieting
- Body piercing
- Excessive exercise
- Smoking
- Drinking

The continuum concept featured strongly in the work of the NSHN between 1995 and the turn of the millennium. In their 1998 publication *The "Hurt Yourself Less" Workbook*, the scope of the continuum was emphasized:

> [By] self-harm we mean *any activity that you do to yourself that is not kind or hurts yourself*. For many people this is cutting, burning, overdosing, alcohol. . . .You may find you have your own self-harm continuum. (NSHN, 1998, p. 30, emphasis added)

Louise Pembroke (1999) later summed up the meaning succinctly: "self-harm is a continuum and we are *all* on it" (p. 39, emphasis added). The emphasis ("all") matters here because it sums up the way in which the continuum concept resists the code. By stressing the *universality* of self-harm ("*we* are *all* on" the continuum), the NSHN uncovered an aspect of the code that Stengel and Jeffery only dimly discerned: essentially, it is a form of *discrimination* directed *against* the self-harmer by the public and professionals alike. It is precisely in this sense that the category DSH *isolates* the self-harmer in comparison with the "good patient" but also in comparison with the professional. In other words, the vocabulary of negative value surrounds *only* the self-harmer; it does *not* surround the good patient or the professional. Yet, by stressing the universality of the self-harm continuum, survivors resisted that assumption of superiority that those that police the code claim to possess. In a sense, survivors imply that *we are all self-harmers now*.

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That recognition has a surprising effect. If "we are all self-harmers now," two possibilities follow: either (a) *we* are *all* subject to the vocabulary of negative value—the drinker, smoker, body piercer, and so on now *all* fall victim to the "insults" that the self-harmer has for so long endured—or (b) we shall have to suspend the vocabulary of negative value and *revalue* self-harm. In stressing this second possibility, "survivors" pursued a tradition that began with the *feminist* practice of asserting the positive aspects of "self-destructive" behaviors. Susie Orbach (1986), for instance, had revalued "eating disorders" in exactly this way: "feminism has taught…that *activities that appear to be self-destructive are invariably adaptations, attempts to cope with the world*" (p. 11, emphasis added).

In other words, viewed as "attempts to cope with the world," anorexia/bulimia may be possessed of *positive* value. Survivors, however, radicalized Orbach by extending the range of revalued behaviors while simultaneously resisting the claims to superiority of the professionals. Provocatively, when conducting training events *for* professionals—a frequent aspect of survivor activism during this period—they (the professionals) were encouraged to "explore *their own* self-harm" (Pembroke, 1994, p. 56, emphasis added). Such activism resists the code by undermining that claim of superiority that permits the professional to isolate and then discriminate against the self-harmer.

It would be a mistake, though, in surveying survivor activism to conclude that they were irretrievably hostile toward service providers or that, in seeking to revalue self-harm, they in fact *celebrated* it. Unlike some traditions of mental health activism, self-harm survivors consistently sought *dialogue* with professionals and in seeking the constructive reform of service provision supported aspects of the welfare state such as emergency medicine. Politically, survivors developed a network of alliances that included psychiatrists, psychologists, general practitioners, psychiatric and general nurses, plastic surgeons, and the British Red Cross (see Cresswell, 2005b). The activism of NSHN is a model of such "networking": both publications of the period 1995–2000 were provided with forewords by prestigious professionals (Barker, 2000; Thomas, 1998), while the "Risk Reduction" conferences of 1999 included contributions from the British Red Cross, a plastic surgeon, nurses, and medical students (see Pembroke, 2007).

[AuQ8]

Occasionally, survivors are characterized as condoning or even *celebrating* self-harm. That is a myth. One searches in vain in their activism for even a hint of the idea that self-harm is considered either a lifestyle choice or a subcultural category. In fact, as with Orbach's recognition of anorexia/bulimia as a "painful" activity, survivors' personal narratives testify that self-harm is a complex phenomenon that emerges to cope with distress and is often related to trauma (see Cresswell, 2005a, 2005b, 2007; see also LeFevre, 1996). What survivors *did* insist on was the discriminatory effects of the code and the need to revalue self-harm as a "painful" way to "cope with the world." Diane Harrison (1995) summed up their position with clarity: "I have been accused of "celebrating self-harm.… While I do not celebrate self-harm itself, I do celebrate women's resourcefulness in impossible situations" (p. 72).

One question emerging from the previous discussion is the following: in resisting medicine's moral code, do survivors argue that *no* aspect of that code is appropriately applied to self-harm? The question requires careful addressing because insofar as the code *is* a discriminatory code, the opposition to it must be "lock, stock, and barrel." On the other hand, though the code wields moral categories in a discriminatory fashion, it does not follow from this that all are discriminatory in quite the same way.

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It is not a question here of detecting traces of validity in such discriminatory categories as "rubbish," "attention seeking," "a nuisance," and so on. There are none to be found. But in recalling that self-harmers were called "irresponsible" and simultaneously implored to "take responsibility" for their actions, it is worth reflecting on the category of "responsibility" being here invoked. In fact, survivors *did* accept that the moral category of "responsibility" may be appropriately applied to self-harm and, moreover, that they *themselves* should apply it. Indeed, the NSHN's *reworking* of the way in which a code of "responsibility" did apply to self-harm is closely connected to a practice that was to become central to their activism in the period in question: *harm minimization*.

The article closes with a brief account of that practice. We shall see that in reworking a moral category deployed in a discriminatory code, "survivors" resisted that code by deploying an *alternative* code of their own.

HARM MINIMIZATION

Harm minimization cannot be separated from the expanded definition of the "continuum concept" sketched out previously; *that* is precisely the context in which the category of "responsibility" gets reworked. Just as the continuum concept of self-harming behaviors stressed its *universality* ("*we* are *all* on it"), so responsibility should, survivors argued, be universally applied *across the continuum*. This reworking strategy was summarized like this:

> Self-harm is a continuum and we are all on it. . . . We . . . all have a *responsibility* to limit the effects of our distress and self-harm on others. Stopping doesn't have to be a goal; rather the goal is managing it and finding the *least damaging option*. (Louise Pembroke, in Fursland, 1999, p. 39, emphasis added)

Again, by stressing that responsibility applies across the continuum (smoking, drinking, and so on), survivors undermined that sense of professional superiority that enabled the code to isolate them in the first place. Once that is resisted, a path opens up to consider the *specific* form that responsibility takes when applied to self-injury/poisoning. This reworking of the responsibility issue was not a sudden discovery; it emerged from collective reflections that may be traced back to BCSW (see Ross, 1988) and the "Looking at Self-Harm" conference, culminating in the activism of the NSHN. The key innovation was to link responsibility, not to "stopping" self-harm as the code demands but, instead, as Pembroke stated, to the "least damaging option." This is the meaning at the heart of harm minimization. *The least damaging option* was addressed by Andy Smith under the heading of "the role of the safety kit in clipping the cycle" (in Pembroke, 1994, p. 19), and his account is worth stating at length:

> The role of professionals in my ceasing to self-harm is negligible . . . an integral part of the damage was the vilification by the Accident & Emergency staff, so *I would carry a safety kit* consisting of: a clean sterile blade with which to cut myself, a tube of antiseptic cream, cotton wool, Butterfly steri-strips, plasters and a Crepe bandage. With this *I could successfully limit the damage* to myself, my self-esteem and my reputation. (emphasis added)

Such advice was developed further by the NSHN and formed the centerpiece of their milestones of activism in the period 1998–2000: *The "Hurt Yourself Less" Workbook* (1998), the "Risk Reduction Conferences" of 1999, and *Cutting the Risk: Self-Harm, Self-Care and Risk Reduction* (2000). One example demonstrates the influence of this activism. In Pembroke's introduction to *Cutting the Risk* in 2000, she outlined the benefits members of the NSHN had derived from harm minimization:

> Some members . . . actively choose not to seek treatment, and carry clean blades and a first-aid kit. This has enabled some to feel in greater control over their self-injury. It's about choice and *minimising risks* whilst we live with self-harm. Facing the practical reality of looking after ourselves. (NSHN, 2000, p. 5, emphasis added)

Harm minimization remains a controversial practice, though there is also evidence of acceptance among some service providers today.[1] The controversy arises because the code interprets the responsibility appropriate to self-harm to mean exactly the same as *stopping* self-harm. If the self-harmer is not suicidal, is neither "genuinely" ill nor had an accident, the code weighs her up as irresponsible; it follows, then, that to become responsible, she has to stop the self-harm—hence the professional obsession, from the 1980s on, of seeking a "contract" with the self-harmer, the chief clause of which would be her agreement *not* to self-harm (see Bloom & Rosenbluth, 1989; O'Brien, Caldwell, & Transeau, 1985). This "contractual" approach to policing the code was, as Sharon LeFevre demonstrated, not really an "agreement" at all; it was a form of "bullying" (see LeFevre, 1996, p. 45).

Yet, once considered from the survivor perspective, harm minimization seems entirely pragmatic—a point survivors have frequently stressed:

> Self-harm is a survival strategy . . . the only way to get them to reduce the harm . . . or stop . . . is through acceptance and engagement, working with their behaviour while learning about it. This requires the adoption of a *pragmatic* approach to maximise the client's safety while he or she continue to self-harm. (Pembroke, 1998c, p. 38, emphasis added)

[AuQ9]

We should note that this "pragmatic" approach included recognition of its own *limitations*; that is, harm minimization is a self-critical code rather than, like medicine's code, an ideological dogma. For instance, while the NSHN provided advice for the self-harmer caught in a pattern of *self-injury* (e.g., "cutting"), they were scrupulously "responsible" in refusing to extend this advice to the *self-poisoner*—precisely on account of the fact that, in the case of an overdose, there was *no* practical way to find the "least damaging option": "we were very clear that *harm-minimisation principles did not apply to any internal damage such as overdoses* because internal damage cannot be seen nor assessed except by medical testing at hospital" (Pembroke, 2007).

[AuQ10]

This quotation is a prime example of how survivors' alternative code resisted medicine's moral code while providing a reflective account of "responsible" and "safe" self-harm: it *could* be responsible for self-injurers to practice harm minimization—*The "Hurt Yourself Less" Workbook* and *Cutting the Risk* showed them how—but such "responsibility" could not apply to the overdoser who, to act "responsibly," had to practice either "safer" self-harm or else enlist immediate medical help (see NSHN, 2000, pp. 6–7).

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CONCLUSION

With these notes on responsibility in mind, it is time to sum up the challenge posed to the code by the alternative code of survivors. That challenge is this:

1. Medicine's moral code, it has to be emphasized, is a *discriminatory* code. The task for professionals remains to confront the challenge to service provision that this realization invites. In other words, *they* have a "responsibility" too. True, Stengel and Jeffery first detected the code, but it was only self-harm survivors who, moving beyond the level of criticism, demanded reform. They thus initiated what has since become known as a "politics of self-harm" (Spandler & Warner, 2007). Yet it is necessary to recognize that harm minimization, together with the reworking of responsibility that it entails, arose precisely *because* of the experience of discrimination, especially in A&E. This is why harm minimization must be considered first and foremost a productive *resistance* to power—a relation about which self-harm survivors were always abundantly clear. Those who continue to find harm minimization controversial should perhaps reflect that this alternative code did not appear in a vacuum; its origins are in resistance to the "poor practice" (Pembroke, 2002b, p. 20) of the code itself. Perhaps, as some professionals are beginning to realize, this recognition introduces a positive prospect—that of a *democratic* reworking of the category of "responsible" professional care and, hence, of a *true dialogue* between givers and receivers of care.
2. Finally, what follows from this recognition is that such dialogue may only be based on *resistance* to medicine's moral code. As this article has shown, that code does not concern "punishment" solely but also a complex of discriminatory attitudes that weigh up self-harm. It seems, then, that a "true dialogue"—which is to say, a *democratic* dialogue—has to be based on a *newly responsible code*, one that redefines the relation between self-harm and moral value—on a code, in other words, that will not stack up all its positive terms on *just* one side of the scale (in favor of suicide, accident, and illness) and then all its negative terms *just* on the side of self-harm. Where moral values and self-harm are concerned, we need to rebalance the scale.

This is not, to repeat, a case of *celebrating* self-harm. It is a case of conceding a sphere of positive value. The alternative is to regard it only negatively, as Gillian Mezey regarded it in the opening quote of this article, with *revulsion*. Of course, as we have seen, "revulsion" turns out to be just one entry in a long list of entries in a vocabulary of negative value. But to revalue self-harm is to truly embrace that responsibility that is part and parcel of dialogue—to accept it, as Louise Pembroke (1994) did, as "a painful but understandable response to distress. . . . [It] is about . . . self-preservation . . . and coping with the uncopeable" (p. 1).

Self-harm, it turns out, is not so much about a fact as a *value*.

NOTE

1. The Royal College of Nursing's Annual Congress 2006 discussed the issue, asking "Safe Self-Harm—Is It Possible?" and, though raising concerns about professional accountability and ethics, also showed some sensitivity to the views of survivors (see the conference report at http://www.rcn.org.uk/downloads/congress2006/reports_agenda.pdfch—consulted 14/09/07). The whole issue of the ethical and legal aspects surrounding harm minimization is the subject of a forthcoming DVD from the survivor-led National Self-Harm Minimisation Group, *Cutting the Risk*, which features contributions from prominent survivors, academics, professionals, and legal experts.

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