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Abstract

This paper re-considers the relevance of Peter Sedgwick's *Psychopolitics* (1982) for a politics of mental health. *Psychopolitics* offered an indictment of 'anti-psychiatry' the failure of which, Sedgwick argued, lay in its deconstruction of the category of 'mental illness', a gesture which resulted in a politics of *nihilism*. 'The radical who is only a radical nihilist,' Sedgwick observed, 'is for all practical purposes the most adamant of conservatives.' Sedgwick argued, rather, that the concept of 'mental illness' could be a truly *critical* concept if it was deployed 'to make *demands* upon the health service facilities of the society in which we live.'

The paper contextualizes *Psychopolitics* within the 'crisis tendencies' of its time, surveying the shifting welfare landscape of the subsequent twenty five years alongside Sedgwick's continuing relevance. It considers the dilemma that the discourse of 'mental illness' – Sedgwick's critical concept - has fallen out of favour with radical mental health movements yet remains paradigmatic within psychiatry itself. Finally, the paper endorses a contemporary perspective which, whilst necessarily up-dating *Psychopolitics*, remains nonetheless 'Sedgwickian'.

Keywords: social movements, crisis tendencies, mental health, anti-psychiatry, political alliances

1. Introduction: Peter Sedgwick and *Psychopolitics*

Peter Sedgwick (1934-1983)[1] was a Marxist, a trained psychologist and the translator of the revolutionary Victor Serge (1963). Unlike most Marxists, Sedgwick took a personal and political interest in the fields of psychiatry and mental health, bringing his 'great wit, compassion and political precision' (Widgery, 1991) to bear on a historically neglected field: the welfare of the 'mentally ill'. Like the contributions of second-wave feminism (e.g. Rowbotham *et al* 1980), Sedgwick understood any human experience as combining the *personal* and the *political* and carried over that perspective into his analysis of psychiatry. He took seriously the value of political theory for understanding this field, whilst nevertheless insisting upon a humanistic appreciation of mental distress. Using his book *Psychopolitics* (1982) as the stem text, this paper re-evaluates Sedgwick's contribution and re-considers the implications of his critique for a contemporary politics of mental health.

The paper is structured in the following way. The next section historicizes *Psychopolitics* within the British context of the 1980s. Jurgen Habermas's notion of 'crisis tendencies' (1976) is deployed to specify Sedgwick's critique in terms of, respectively, three 'crises': i) a crisis of British welfarism; ii) a crisis of Left-wing politics; and iii) a crisis of psychiatric legitimacy. This critique, which is outlined in Section 3, is posited as transecting these crises. Given that Sedgwick's work is historically specified, Section 4 explores the value of his critique in the contemporary context. We argue that, whilst in certain respects history has problematized this critique – and we specify that

problematization - Sedgwick's approach to questions of political strategy retains its value today. The final section argues the case for a politics of mental health which, whilst updating *Psychopolitics*, remains nonetheless 'Sedgwickian' (Spandler, 2007).

2. Historicizing *Psychopolitics*

Sedgwick (1955) first deployed the term 'psychopolitics' in the 1950's when criticising the tendency to explain away political activism via individual psychology, drawing attention to the ways in which communist sympathizers had been pathologized in the West. Later, his critical focus turned to the conservative undercurrents of the radical theorists associated with 1960s 'anti-psychiatry' (e.g. Sedgwick 1972; 1973; 1975). *Psychopolitics* sums up this analysis. The historical specificity of the book is central to its understanding so that any attempt to re-consider it requires its contextualisation as the political critique it was doubtless intended to be. Viewed in this way, *Psychopolitics* transects three inter-woven axes, each axis signifying certain 'crisis tendencies' of his time (see Habermas, 1976).

Axis#1 – signifying a *British* context which had witnessed the end of the 'long boom' of post-War affluence predicated upon the emergence of the welfare state (see Coates, 1995) and the rise of a 'New Right', embodied in the figure of Margaret Thatcher, which sought to dismantle that state whilst simultaneously exposing it to the 'chill winds of market forces' (see Gamble, 1990). The subsequent *Crisis of Welfarism* heralded the marketisation of welfare (see Leys, 2001).

Axis#2 – signifying a context of *Left-wing* activism which had become fractured with the rise of the 'New Right' and the calling into question by social movements of a 'class-first' policy insensitive to emerging identity-claims (see Hall, 1996). To fully situate *Psychopolitics* within debates on the Left, it is necessary to note that it appeared within a time-span which also included Eric Hobsbawm's (1978) 'The forward march of Labour halted', Stuart Hall's (1979) 'The great moving right show', Sheila Rowbotham, Lynne Segal and Hilary Wainwright's (1980) *Beyond the Fragments,* and Ernesto Laclau and Chantal Mouffe's (1985) *Hegemony and Socialist Strategy* (Laclau and Mouffe 1985). Sedgwick, then, was intervening upon similar terrain and responding to particular problematics within the organised Left of his day. If Axis#1 signifies a crisis in British Welfarism, Axis#2 signifies a *Crisis of the Left*.

Axis#3 – signifying the field of *mental health politics* and the emergence of social movements organizing around themes of human distress. Sedgwick was fully au fait with *both* the counter-cultural phenomenon of 'anti-psychiatry' associated with the figure of R.D. Laing (e.g. 1967) *and* the emerging 'patient's movement' represented by such groups as the Mental Patient's Union (see Crossley, 2006a; Spandler, 2006). Such developments ensured that psychiatric power – hidden for so long behind the 'gigantic water-tower' of the Asylum age (see Bell & Lindley [eds.], 2005) - was becoming, in an era of 'community care', both a *contested* and *visible* 'field' (Crossley, 2006ab). Such contestation signifies what may be called the *Crisis of Psychiatric Legitimation*.

The notion of ‘crisis tendencies’ refers to that dynamic within ‘advanced capitalism’ (Habermas, 1976, 33-94) for ‘system crises’ to undergo a displacement from their economic ‘base’ (Marx, 1968, 182) to one situated at the interface of the state and civil society. Such ‘social crises’, in contrast to ‘system crises’, do not threaten the capitalist system as such, but are, rather, crises at the level of ‘social integration’. ‘Legitimation crises’, as a sub-species of ‘social crises’, arise insofar as the democratic ‘outputs’ of the state fail to meet the democratic ‘demands’ of civil society, ‘demands’ which, to a large extent, welfare state intervention triggered in the first place (Offe, 1984). In an important sense, then, a ‘legitimation crisis’ is a crisis of a democratic polity, a calling into question of its democratic status. As Crossley (2005, 40-50) points out, apropos Habermas’s later amendments (1981), the rise of new social movements, including mental health movements, are stimulants of ‘legitimation crises’ to the extent that, in the case considered here, movement-articulated ‘demands’ are precisely those ‘demands’ for democratic ‘outputs’ from psychiatry, considered as a welfare state apparatus, which psychiatry is frequently unable to meet.

In this respect, Sedgwick’s analysis is exemplary. Not only is he sensitive to these ‘crisis tendencies’ at the interface of the state and civil society (Axis#1), he is also able to *specify* these tendencies *both* for the mental health field (Axis#3) *and* for Left-wing activism within it (Axis#2) whilst never losing sight of the wider context beyond. Accordingly, in *Psychopolitics* these axes interweave in the following way. Axis#3 – the field of political action ‘in and against’ psychiatry (‘psychopolitics’) – is always the foregrounded axis so that the elucidation of a distinct ‘psychopolitics’ constitutes the

books most lasting achievement. On the other hand, the explication of Axes 1 & 2 is absolutely necessary to the critique insofar as it contextualizes the significance of this specific 'field of contention'. It is only within the overall context of the 'great moving right show' and the urgent tasks faced by the organised Left in an era of *both* Right-wing resurgence *and* proliferating identity-claims, that the import of Sedgwick's analysis fully swings into view. We will keep these axes of contextualization always in view as we turn, in the next section, to the details of Sedgwick's critique.

3. Central critique of *Psychopolitics*

Psychopolitics may be divided into three parts. First, Sedgwick advances a definition of mental illness which refuses to erect a strict dualism between mental and physical health. He thus adopts a *unitary conception of 'illness'* beneath which is subsumed both physical and mental aspects. This move proves decisive because, in the second part of the book, he evaluates a number of radical critics of psychiatry (the 'anti-psychiatrists') and finds them guilty of insinuating into psychiatric debates a nihilistic form of critique which he calls 'psycho-medical dualism' (1982, 43-65). These 'ideological celebrities', as Sedgwick dubs them (1982, 3), are Erving Goffman (1961), R.D. Laing (1967), Michel Foucault, (2006) and Thomas Szasz (1974). Having despatched these critics in turn, Sedgwick finally considers the current state of 'psychopolitics' itself along with its future prospects.

In order to grasp the value of Sedgwick's critique, we must not misconstrue his *philosophical* discourse; specifically, his rejection of psycho-medical dualism in favour of the unitary conception of illness noted above. Sedgwick is not offering a philosophy of psychiatry here in the analytical vein (e.g. Fulford *et al*, 2003). Rather, operating within a Marxist tradition of social critique (Marx, 1969), Sedgwick offers a distinctively *political epistemology* (Lecourt, 1975) of the concept of 'illness.' The minutiae of this argument need not detain us, but the upshot must. For, contra Laing, Goffman *et al*, Sedgwick rejects the 'mind-body' duality upon which their 'psycho-medical dualism' rests. Briefly, 'psycho-medical dualism' posits *medicine* as a scientific realm of 'fact' which takes as its referent the materiality of the body, and to this it contraposes *psychiatry* as a realm of 'value' which, rather, takes as its referent the uniqueness of the human mind. According to this perspective, there is a world of difference between a *value-neutral* diagnosis such as 'diabetes' and a *value-laden* one such as 'schizophrenia'. The former is a *scientific* classification; the latter is *deviancy* labelled by power.

Sedgwick works in the opposite conceptual direction to 'anti-psychiatry'; he takes its basic motif – that of 'value-laden-ness' - and drives it into the heart of medicine itself. Hence, for Sedgwick, all illness '*is essentially deviancy*' (1982, 32, original emphasis) and, therefore, equally laden with 'value':

> '[q]uite correctly, the anti-psychiatrists have pointed out that psychopathological categories refer to value judgements and that mental illness is deviancy. On the other hand, the anti-psychiatric critics themselves are wrong when they imagine physical medicine to be essentially different in its logic from psychiatry…*mental illnesses*

> *can be conceptualized within the disease framework just as easily as physical maladies*' (*ibid*., 38, emphasis added).

Sedgwick's conception is subtle and needs to be carefully rendered. In stressing the value-laden-ness of medicine, it is not his intention to disregard its scientific credentials. At the same time, in subsuming a diagnosis of 'schizophrenia' within the 'illness framework', neither is he endorsing psychiatry's epistemological claims. Sedgwick is *pro*-medicine precisely to the extent that he envisages a *radically socialised* medicine applicable equally to physical *and* mental health. Such examples of socialised medicine include, '[t]he insertion of windows into working-class houses' (*ibid*., 39) and 'the provision of a pure water supply and an efficient sewage disposal' (*ibid.).*

This is why Sedgwick's unitary conception of illness is, before anything else, a political epistemology and, as such, inextricably connected to the conditions of possibility for future political work. Thus, for Sedgwick, the productiveness of the concept of 'illness' resides in the prospect of 'politicising medical goals' (*ibid*., 40):

> 'I am arguing that without the concept of illness – including that of mental illness…we shall be unable to *make demands* upon the health service facilities of the society in which we live' (*ibid*., original emphasis).

It is this injunction – that a political epistemology should lead to 'demands' - that moves Sedgwick to a decisive indictment of the anti-psychiatrists. For despite their brilliant deconstructions of 'schizophrenia' et al, they are bereft of any productive *demands* of their own:

> '[t]he sociological critics of the mental illness concept are…deeply cynical…and the cynic cannot really be a critic; the radical who is only

> a radical nihilist…is for most practical purposes the most adamant of conservatives' (*ibid*., 42).

In relation to the axes of contextualization sketched out above, Sedgwick's analysis is exemplary because, not only does he identify the limitations of 'anti-psychiatry', he is *also* critical of the organised Left's long-standing neglect of the mental health field. Despite his own political commitments, he refused to ignore reactionary tendencies amongst workers and health trade unions in relation to mental health:

> '[t]he mental-health services now comprise a constellation of partial staff interests, whose trade-union representation runs along the lines of this alienated institutional order…In this era of psychiatric monetarism…the mental health worker is forced into a defensive…stance because of a fear that a more adventurous approach will further worsen his or her conditions' (*ibid*., 234-235).

Whilst Sedgwick recognised the importance of the economic 'base' for psychiatric provision 'via the operations of general systems of public assistance' (1982, 203), he did not automatically assume that the resolution of the *Crisis of Psychiatric Legitimation* would be effected by 'economistic' means - say, by a 'workerist' defence of 'jobs and conditions' (1982, 230). At the same time, Sedgwick was equally critical of the 'considerable crudity' with which issues of mental health *had* been politicised by those sections of the Left which sometimes supported 'anti-psychiatry' along with its central motifs. Such approaches tended to 'romanticise' madness, reifying the dissident mental patient as a substitute revolutionary force. Always sensitive to its personal and political aspects, Sedgwick fretted over the 'extraordinary burden' such expectations placed upon

the mentally ill: they were to be either i) inserted epiphenomenally into an already given class ideology in which the specific content of their distress was forever elided; or else ii) co-opted as 'a cadre in the assemblage of counter-forces…in antagonism to our…oppressive society' (*ibid*., 237-8).

Notwithstanding these reservations, Sedgwick remained adamant that the field of mental health *must* be a site of activity for the organised Left. He was pessimistic about the prospects of mental health movements acting alone; their defensive assertion of 'negative rights' (*ibid*., 218-221) amounted to nothing more, he argued, than 'the ritualistic evasion of the serious questions of long-term psychiatric care' (*ibid*, 241). Yet he bemoaned the fact that the task of integrating cross-sectional demands 'has never been undertaken by the organised left, despite its pretension to possess a reasoned and principled overview of the social order' (*ibid*., 236).

With this aim in view, Sedgwick analysed the processes and paradoxes of making 'psychopolitical' demands. He endorsed the need for active social movements able to politically transect the axes of contextualisation sketched out above; that is to say, to build 'cross-sectional' (*ibid*., 243) alliances with patients, carers, professionals *and* the organised Left in order to pursue collective welfare demands. Such 'cross-sectional alliances' meant, in the first instance, '*working within the publicly funded system of heath and social-welfare provision*' (*ibid*., 244-255, original emphasis). Yet he was also acutely aware of the:

> 'dilemma of all innovators for whom the present state-run facilities offer little in the way of a model, and even less in the way of

> inspiration, is that of engineering a voluntary alternative model of care which will not abdicate from the *broader responsibility of posing more general and long-term demands*' (*ibid*., 245, original emphasis).

Thus, he ended *Psychopolitics* with some prefigurative examples of 'mutual aid', drawing upon the anarchist tradition (e.g. Kropotkin, 1908) to insist upon the 'countervailing power of voluntary social initiative, outside the bureaucratic compass of the state' (Sedgwick, 1982, 252), practices which were 'voluntarily conceived, yet, materially implemented' (*ibid*., 256). 'Psychopolitical' struggle, finally, is, for Sedgwick, Janus-faced; for it looks both towards reclaiming the state (see Wainwright, 2003), in the guise of 'publicly funded…social-welfare provision' and towards emancipatory experiments emanating primarily from the 'voluntary' sector. With characteristic comprehensiveness, Sedgwick observed that we need both of these sectors precisely because they answer to different questions: the 'base' question of political economy (i.e. resource allocation) as well as 'wider…questions of medical politics' (*ibid*., 194). These 'wider questions' do not concern the quantitative question solely (resource allocation) but also the qualitative question of 'what kind' of psychiatric services we need (ibid., 195). For Sedgwick, it was precisely responding to this latter question that necessitates *both* reclaiming the state *and* emancipatory experimentation.

4. 'Psychopolitics' Today

We have grasped the specificity of *Psychopolitics,* then, via its central critique and the axes of contextualisation outlined above. Yet, an obvious question remains. How should

we survey the field of 'psychopolitics' today? The intervening twenty five years have seen profound global and national transformations as well as changes in the mental health field – transformations which Sedgwick, perhaps, could not have foreseen. However, far from being resolved, the 'crisis tendencies' that contextualised Sedgwick's original intervention, remain extant today. This is not the same as saying that they have just remained the same. We stress the *historicity* of crisis tendencies rather than their structural inertia. As such, we would analyse these changes in the following way.

Axis#1: Re: Crisis of British Welfarism

We have witnessed a *consolidation* of neo-liberal hegemony with regard to the *Crisis of Welfare*. In the British context, an escalation of 'Thatcherism' in the form of a 'market-driven politics' (see Leys, 2001) has penetrated what had hitherto been bureaucracies (e.g. the NHS) and the endorsement by New Labour post-1997 of that entrepreneurial form of governance described as the 'new public management' (see Du Gay, 1996). We view 'Blair/Brownism' as an escalation of 'Thatcherism' rather than a qualitative 'break'. At the same time a 'mixed economy' of care has become the 'common-sense' of 'governmentality' (see Burchell *et al*, 1991) in the wake of the economic constraints imposed on the public sector by, for example, the *NHS & Community Care Act* (1990). This has led to a proliferation of '3rd Sector' (voluntary) service provision, of a type alluded to in favourable terms by Sedgwick (1982, 248-249), although the specific transformations of that sector are not of the type he may have foreseen.

Axis#2: Re: Crisis of the Left

We have witnessed a deepening of the *Crisis of the Left* with regard, not only to internal sectarianism, but to a failure to re-orient political strategy in an 'age of movements and

networks'.[2] Far from 'dying the death', Left-wing activism in Britain has persisted, with predictable vicissitudes, alongside a proliferation of 'even newer' social movements e.g. anti-globalisation networks and 'eco-politics' (Crossley, 2003) which make both distributive and identity-claims. However, various attempts at 'unifying' the Left in Britain (e.g. through, first, the 'Socialist Alliance', then the 'Respect' coalition) have not been sustained and it remains unclear whether such organisations interact with social movements in a politically meaningful way.[3] With some notable exceptions (e.g. SHA 1989), the Left have, by and large, failed to engage with the broader politics of mental health of which Sedgwick was so acutely aware, when, for example, campaigning in defence of jobs and services and against privatisation and 'cuts' (Coleman 1998; McKeown 2008; Mckeown *et al*. 2008). Neither the 'anti-psychiatric' critics, nor the organised Left, it seems, have adequately responded to Sedgwick's critique, whilst psychiatry continues to experience its *Crisis of Legitimation.*

Axis#3: Re: Crisis of Psychiatric Legitimation

In response to that crisis, psychiatry has, at one and the same time, *expanded* the 'illness' category into hitherto 'undiscovered' fields of human experience whilst simultaneously bolstering its claims to scientificity via a thoroughgoing biologism and its claims to legitimacy via the extension of lawful coercion. These strategies have encountered resistance.

Indeed, the mental health field has witnessed an *explosion* of such resistance with a proliferation of networked, but rarely hierarchically co-ordinated, movements and groups. Some of the most significant of these, for the British experience, have been Survivors Speak Out (Campbell, 1989), The Hearing Voices Network (James, 2001), the National Self-Harm Network (Pembroke, 1995) and Mad Pride (Curtis *et al*, 2000). The increasing heterogeneity of user groups has resulted in recent attempts to unify the 'user voice' through a national forum, a move which has provoked controversy regarding issues of democratic representation and the dangers of co-optation (Pilgrim, 2005).

These developments have *not* borne out Sedgwick's pessimistic views about: i) the possibility of autonomous political action by service users; nor ii) that a nihilistic conservatism inevitably follows adoption of 'anti-psychiatric' motifs; nor iii) that patients groups would necessarily adopt a purely defensive, 'negative-rights' based agenda, which is always *against* psychiatric 'abuses' but never *for* psychiatric 'uses' (Sedgwick, 1982, 218-221). On the contrary, whilst such movements have been highly autonomous, they have been simultaneously the product of *alliances* between workers, service users and political activists (notably feminists). Moreover, these have led to the 'development of new programmes, demands and services' from service users *and* workers alike, 'demands' which Sedgwick neither realised nor anticipated (Sedgwick, 1982, 222). For example, the politicisation of issues such as 'self-harm' and 'hearing voices' – which psychiatry traditionally subsumes beneath 'illness' categories - has resulted in a number of self-help strategies and practices such as 'harm minimisation' (Cresswell, 2005ab) and 'coping with voices' (Blackman, 2007) pursued via non-medical, consensual means.

Such developments have also challenged Sedgwick's insistence that the 'unitary conception of illness' is *the* necessary precursor to politicisation of the mental health field.

In fact, the organisations noted above have explicitly rejected the notion of 'illness'; and have sought instead to locate the specificity of experience, such as 'hearing voices' or 'self harm', deploying alternative concepts and frameworks such as 'mental distress' (Campbell 1989; Plumb 1999) or even 'madness' (Curtis *et al*. 2000). The mobilisation of such groups has revolved around the discursive ensemble 'trauma/abuse/distress' rather than the 'Sedgwickian' ensemble 'illness/disease' (see Cresswell, 2005ab). Such frameworks attest to the importance of personal histories of trauma and abuse (Herman, 1994), as well as iatrogenic degradations experienced within the mental health system itself (see Breggin, 2008).

However, the 'unitary concept of illness' *has* persisted in a powerful quarter of the mental health field. For it has been liberal campaigners as well as, of course, psychiatry itself, that continue to deploy the 'illness' category as part of a strategy of 'psychiatric expansionism' (Castel *et al*., 1979), especially in so-called 'anti-stigma' campaigns (see Pilgrim & Rogers, 2005). These are often underpinned by the Sedgwick-sounding mantra: 'mental illness is an illness like any other'. Such campaigns seek to bolster the legitimacy of a reductive biological approach within psychiatry, alienating in the process many user movements and groups whilst not necessarily fulfilling their anti-discriminatory aims (see Read *et al*., 2006).

Whilst Sedgwick was right not to erect a crude dualism between the mental and physical per se, the concept of 'illness' *is* problematic, and this is not just a deconstructivist obsession with language. Moreover, contra Sedgwick, Cresswell (2008) has argued that Thomas Szasz's own brand of 'psycho-medical dualism' - despite the limitations of Szasz's own Right-wing ideology which Sedgwick critiqued (1982, 149-184) - *is* defensible for a number of reasons, independent of that critique. Psychiatry and medicine must be distinguished at the level of material practices and these practices consist of epistemological (e.g. scientific), ethical (e.g. coercion and consent) and technological (e.g. diagnosis and treatment) aspects. Regarded in this sense, psychiatry and medicine do not exist on a par in quite the way that Sedgwick's 'unitary concept of illness' would have us believe. Unlike medicine, for example, where treatment is rarely *imposed*, psychiatric 'technology' is bound up, like a 'conjoined twin' (Szasz 2004, 53), with mental health laws which enable and enforce *coercion*. This fact strikes to the heart of the *Crisis of Psychiatric Legitimation* but is somewhat elided in Sedgwick. Let us be clear on this point. It is not the deployment of the category of 'illness' that *necessarily* leads to coercion – it does not in medicine - rather, the point to be emphasised is that psychiatric coercion is both legitimised by the state whilst being notoriously prone to abuses (see Johnstone, 2000).

Indeed, it is precisely opposition to the *extension* of coercive powers that has unified various organisations within the mental health field. Recent years have witnessed an attempt by New Labour to render it lawful for certain categories of 'patient' to be coercively treated in the community – hitherto, an unprecedented step in English law

(Cresswell, 2005c; Szmukler, 2004). Such proposals, embedded in new mental health legislation in England and Wales, resulted in sustained opposition from a heterogeneous alliance of '3rd Sector' advocacy organisations (e.g. MIND), professional collectives (e.g. the Royal College of Psychiatrists) and service user groups (e.g. the United Kingdom Advocacy Network) combining together beneath the rubric of the Mental Health Alliance.[4] Concerns about coercion also led to the formation of the Critical Psychiatry Network in 1999, a group of dissident psychiatrists who argue that psychiatry has failed to meet the challenges posed by its critics and thus remains deeply mired in its *Crisis of Legitimation* (Double, 2006; Bracken and Thomas, 2005).

To open up possibilities for productive transformation transecting these axes, we argue for an approach which, whilst necessarily up-dating *Psychopolitics,* remains nonetheless 'Sedgwickian'. The final section specifies the meaning of this by analysing the conditions of possibility for a new 'Psychopolitics'.

5. For a new 'Psychopolitics'

Whilst we relate the following conditions to each of the three axes outlined above, any single intervention in one axis is intended to possess a *universalising* potential; in other words, to aspire to a 'cross-sectional' impact. As should become evident, such potentiality makes it truly 'Sedgwickian'.

Strategic Demands - In the context of a *Crisis of Welfarism* and, more specifically, continuing attacks on collective provision, a progressive 'psychopolitics' must continue to make concrete 'welfare demands'. For example, in the current policy context, one which promotes 'individual responsibility' rather than 'socialised provision', a Sedgwickian approach would continue to emphasise the necessity of *public* assistance for people experiencing mental distress.

The development of mental health politics post-Sedgwick has often focused attention on activism 'outside the bureaucratic compass of the state' (Sedgwick, 1982, 252), for example, through the development of local '3rd sector' self-help organisations. Notwithstanding the importance of these, we want to emphasise that it is the *public sector* that constitutes a privileged point of political action. We posit the public sector in this way not out of any partiality or preference but out of the realisation that disputes in that sector possess maximum potential for *universalising* the content of collective welfare demands. We deploy the notion of 'welfare demands' (see Laclau, 2005) to signify both the importance of 'demands' made *in the direction of* the state (centrally and locally) and 'demands' which *crystallise into* disputes within the public sector itself (strikes, fights against privatisation etc.) when, for example, such 'demands' are rejected. Such disputes, which may mobilise a relatively 'critical mass', possess the widest possible potential for alliance-formation – they 'suck' into the public sector, centripetally as it were, social movements, carers groups, trade unions, the Left etc. - and, hence, permit strategic welfare demands to be made which possess the widest possible political force.

It follows from this that we must take seriously the defence of the core institutions of welfare: the NHS and local authority provision. This requires an active workforce committed to a radical 'psychopolitics', the importance of trade union mobilisation within it and an organised Left armed with a 'reasoned and principled overview of the social order' (Sedgwick, 1982, 236). However, a progressive 'psychopolitics' also needs to reconstitute its understanding of what we mean by 'the public sector', 'the 3rd sector' and, increasingly, the imbrication of the two. In an era of 'mixed economies', the '3rd sector' is not the undiluted sphere of 'mutual aid' that Sedgwick envisaged. But neither is it *just* a way for the state to 'marketise' the public sector through threats of 'competitive tendering'. Indeed, via strategies of governmentality, '3rd sector' organisations are increasingly incorporated into the public sector – through complex funding dependencies, for instance - a move which makes them *both* newly constitutive of welfare demands and *less likely* to pioneer those emancipatory practices of which Sedgwick so rightly approved. On the positive side, the independence provided by the '3rd sector' has enabled a number of women's organisations, black and minority ethic groups and radical disability groups to mount specific challenges to psychiatric legitimacy (see Women at the Margins, 2004; Sisters of the Yam, 2004).

Thus, a 'Sedgwickian' approach must defend *both* collective welfare provision *and* open up spaces of innovation and contestation 'outside the bureaucratic compass of the state' (Spandler, 2004). Whilst such a plea may sound either 'obvious' and/or paradoxical, we would argue that it is precisely a lack of 'cross-sectionality' in this respect that holds back a progressive 'psychopolitics' today. It is clear that mental health movements

cannot fight such battles alone. That 'Sedgwickian' point has been re-emphasised recently by Hilary Wainwright:

> '[w]e cannot point to 'social movements' to get us out of a tight spot. It should be clear by now that movements come and go and cannot be evoked as some self-evident answer to the problem of creating effective agencies of social change'. [5]

Therefore, the capacity to 'make demands' is predicated upon the development of specific cross-sectional alliances – to which point we now turn.

Organisation and Alliance – In the context of the *Crisis of the Left* a progressive 'psychopolitics' requires us to consider the forms of political organisation which will foster the development of active and productive alliance. There is no point in underestimating the paradoxes which underlie this process. Mental health movements are constitutively *heterogeneous* and whilst this tendency was already apparent when Sedgwick penned *Psychopolitics,* it has increased exponentially with the 'quantum leap' of Information and Communication Technologies (ICT) since the mid-1990s (see Castells, 1996, 171). There has, thus, emerged a plethora of small social movement organisations which, nevertheless, because of ICT, possess a national, even a globalised, 'sweep'.[6] Not only is this sort of 'cyber-activism' here to stay (see Papacharissi, 2002), we would suggest that it offers 'psychopolitics' the 'Techno-Political Tools' necessary for the mobilisation and maintenance of 'cross-sectional alliances' (Fuster & Morrell, 2007).

However, such heterogeneity is problematic for the Left in that their dispersed constitution makes mental health movements difficult to liaise with and, sometimes, even to locate. There is no one great mental health movement and no charismatic 'leader' that we could take you to. Indeed, we would say, along with Laclau (2005), that heterogeneity is *constitutive* of the political field under conditions of advanced capitalism and that this has to be accepted as a political point of departure.

A number of consequences attend 'heterogeneity'. 'Cross-sectional alliances', it has to be noted, are not the result of an immaculate conception; neither can they be conjured into existence at a point of political rupture – for instance, in a moment of management victimisation or a public sector strike. 'Cross-sectional alliances' are founded upon the mobilisation of pre-existing communicational networks, painstakingly built, and they have to be *always already* present at the point of political rupture if that mobilisation is to constitute a case of transformative power (Freeman, 1999).

Some of the most productive 'cross-sectional alliances' in the field of mental health have emerged in precisely this painstaking way – from the formation of: i) the Mental Patients Union in 1973 based upon networks of service users, radical professionals and the activist Left, ii) Survivors Speak Out in the 1980s based around networks of 'psychiatric survivors', radical professionals and '3rd Sector' groups (e.g. MIND); iii) the 'self-harm survivors' based upon the confluence of Bristol-based feminist activism (see Wilton, 1995) and 'psychiatric survivors' (see Campbell, 1989/90); and iv) the Residential workers strikes and campaigns against 'cuts' in Sheffield of the 1990s based around

networks of service user groups and a strong trade union (NALGO) in which the organised Left was both a significant force and able to mobilise nationally (see Harrison, 1992)

The difficulty of constituting a 'cross-sectional alliance', therefore, amounts to a problem of *political strategy*. For alliance-formation is precisely the task of constituting a 'logic of equivalence' between heterogeneous political agents (trade unions, Left activists, feminists, 'survivors', professional groups), a logic that is perpetually subverted by the 'logic of difference' which gives rise to their differential 'politicized identities' in the first place (Laclau & Mouffe, 1985; Laclau (ed.), 1994; see also Brown, 1995). In the final section of *Psychopolitics,* Sedgwick's anticipated this dialectic of 'equivalence' and 'difference' alongside its prospects and threats. In being realistic enough about 'difference' he, nevertheless, placed his hopes in 'equivalence'. We choose to do the same.

Conceptual Resources and Ethical Commitments – Finally, if a progressive 'psychopolitics' requires us to make collective welfare 'demands', it also requires a *political epistemology* worthy of the task. A 'Sedgwickian' epistemology today must attend to the contemporary paradoxes of the mental health field. In other words, any 'demands' and 'alliances' must attend to the specificities of the mental health field *plus* the conditions of possibility for future political work.

This is precisely what Sedgwick grasped when he reached for the unitary conception of illness noted above. We would not want to be misunderstood on this point, despite our valuation of Sedgwick's critique. We would repeat our problematization like this. Being 'Sedgwickian', ultimately, means making 'psychopolitical demands'. 'Illness' *may* do that job, *has* done that job, *could* do that job. But it is not the *only* way, especially if its deployment alienates those individuals and organisations required for 'cross-sectional alliances' to form (McKeown, 2008). Deploying 'illness' as an epistemological point of departure obscures the potential to radicalise *how* we view human distress, precisely because it makes it difficult to challenge psychiatry's claims to legitimacy; that is to say, it makes it difficult to problematize *how* psychiatry constructs and colonises human distress in the first place (see Parker *et al*., 1995). Further, the concept of 'illness' now exists within, and is legitimised by, a bio-medical framework which is increasingly contested. The new discursive ensemble that has arisen as paradigmatic of this contestation – trauma/abuse/distress - may also 'do the job'. It is not our intention, however, to substitute for a teleology of 'illness' ('the future belongs to illness' Sedgwick predicted in 1982 [1982, 39]), a teleology of, say, 'trauma' ('the future belongs to trauma'). No such category *universalises* itself to such an extent that it does not provoke paradoxes all of its own (see Furedi, 2003; also Skeggs, 1997, 166-167).

Rather than erect a duality between 'illness' and 'trauma', we argue that a political epistemology must first be *historicized.* That is to say, it must transform its conceptual structure in response to the actual 'experience' of history; in response to the 'working through' of those very 'crisis tendencies' noted above. Shorn of the sheen of scientificity,

we are suggesting a politically salient version of Gaston Bachelard's (2002) notion of 'radical reflexivity' in the process of scientific concept-formation:

> '[W]e must…*deform* our initial concepts, examine these concepts condition of application, and above all incorporate *a concept's conditions of application into the very meaning of the concept.*' (*ibid*., 69, original emphasis).

Analytic precision is necessary here. By 'deform the concept', Bachelard does not mean, 'render it misshapen'. He means 'to break down and reconfigure' it. For Bachelard, the scientist's 'radical reflexivity' is nothing less than an *ethical* stance – whose 'duty' is predicated upon a commitment to science's epistemological norms. From a 'psychopolitical' perspective we would say that 'radical reflexivity' is a *politico-ethical* stance (see Agamben, 1999, 11-14) – where a progressive 'duty' is predicated upon a commitment to the radically socialised 'psychopolitics' that we have outlined above.

Such a 'politico-ethical' commitment constitutes Sedgwick's finest achievement. It retains its value today. Just as he '*de*-formed' the nihilistic conceptions of 'anti-psychiatry' via his 'unitary conception of illness', so he simultaneously '*de*-formed' the figure of the 'mentally ill' as it appeared stereotypically both in the passive imaginary of the organised Left, and as the romanticised revolutionary subject of 'anti-psychiatry'. Whilst we may not agree with *all* of Sedgwick's critique, we do aspire to be as reflexive. 'Radical reflexivity', it turns out, is synonymous with 'Sedgwickian'. *Psychopolitics*

provides both a crucial resource for such a critique *and* a positive framework for future political work.

Endnotes

[1] An internet archive devoted to the Sedgwick's life and work can be found at: http://www.petersedgwick.org/. Consulted 18/07/08.
[2] See 'Any Respect Left' by H. Wainwright URL - http://www.redpepper.org.uk/article689.html - consulted 11/03/08).

[3] Such questions are addressed in an interesting way in the Transnational Institutes *Networked Politics* available at URL: http://www.tni.org/detail_pub.phtml?know_id=39 (consulted on 07/03/08) edited by Hilary Wainwright *et al*.
[4] For more details see URL: http://www.mentalhealthalliance.org.uk/aboutus/index.html_ (consulted 05/03/08).
[5] See 'Rethinking Political Parties' on the *Red Pepper* website (URL: http://www.redpepper.org.uk/article1017.html?var_recherche=rethinking%20political%20parties – consulted 11/03/08).
[6] To name just a selection, organising around the issue of 'Self-Harm': 'Self-Harm Alliance' (URL: http://beehive.thisisessex.co.uk/default.asp?WCI=SiteHome&ID=5423 – consulted 18/04/06); 'Equilibrium' (URL: (http://www.selfharmony.co.uk/ - consulted 18/04/06); 'Self-Injury & Related Issues (SIARI) (URL: http://www.siari.co.uk/ - consulted 17/04/06); 'Lifesigns (Self-injury Guidance and Network Support' (URL: http://www.selfharm.org/index.html - consulted 17/04/06).

References

Agamben G (1999) *Remnants of Auschwitz: The Witness and the Archive*. New York: Zone Books.

Bachelard G. (2002) *The formation of the scientific mind*. Manchester: Clinamen.

Barker C. (2008) Goliath sometimes wins: a strike of community mental health workers in Manchester. *Alternative Futures, Popular Protest: 13th International Conference* Manchester Metropolitan University.

Bell A, Lindley P (eds) *Beyond the Water Towers: The Unfinished Revolution in Mental Health Services 1985-2005*. London: Sainsbury Centre for Mental Health.

Blackman L. (2007) Psychiatric Culture and Bodies of Resistance. *Body and Society* **13(1)**: 1-23.

Bracken P, Thomas P (2005) *Post Psychiatry* Oxford: Oxford University Press.

Breggin P (2008) *Brain Disabling Treatments in Psychiatry: drugs, electroshock and the psychopharaceutical complex.* New York: Springer.

Brown W (1995) *States of Injury: Power and Freedom in Late Modernity*. Princeton, NJ: Princeton University Press.

Burchell G Gordon C & Miller P (eds) (1991) *The Foucault Effect: studies in governmentality.* Chicago: Chicago University Press.

Campbell P (1989) The Self-Advocacy Movement in the UK. In: Brackx A, Grimshaw C (eds) *Mental Health Care in Crisis*. London: Pluto.

Campbell P (1989/90). Self-Harm. *OpenMind* **42**: 18.

Castel R, Castel F & Lovell, A (1979) *The Psychiatric Society*. Columbia University Press, New York

Castells M (2000) *The Rise of the Network Society.* Oxford: Blackwell.

Coates D (1991). *Running the Country*. London : Hodder & Stoughton in association with the Open University.

Coleman R (1998) *Politics of the Madhouse*. Gloucester: Handsell.

Cresswell M (2005a) Psychiatric "survivors" and testimonies of self-harm. *Social Science & Medicine* **61**: 1668-1677.

Cresswell M (2005b) Self-Harm "Survivors" and Psychiatry in England, 1988-1996. *Social Theory & Health* **3**: 259-285.

Cresswell M(2005c) Scare in the community. *Red Pepper* **130**: 30-31.

Cresswell M (2008) Szasz and his interlocutors: reconsidering Thomas Szasz's 'myth of mental illness' thesis. *Journal for the Theory of Social Behaviour* **38(1)**: 23-43.

Crossley N (2003) Even Newer Social Movements? Anti-Corporate Protests, Capitalist Crises and the Remoralization of Society. *Organization* **10(2):** 287-305.

Crossley N (2005) *Key Concepts in Critical Social Theory*. London: Sage.

Crossley N (2006a) *Contesting Psychiatry: Social Movements in Mental Health*. London & New York: Routledge.

Crossley N (2006b) The field of psychiatric contention in the UK, 1960-2000. *Social Science & Medicine* **62(3)**: 552-563.

Curtis T, Dellar R, Esther, L & Watson B. (2000) *Mad Pride: A Celebration of Mad Culture.* London: Spare Change Books.

DoubleDB (2006) *Critical Psychiatry: The Limits of Madness*. New York & Basingstoke: Palgrave Macmillan,

Du Gay P (1996) *Consumption and Identity at Work.* London: Sage.

Equilibrium. URL: http://www.selfharmony.co.uk/

Foucault M (2006*) Madness and Civilization: A History of Insanity in the Age of Reason* London & New York: Taylor & Francis.

Freeman J (1999) On the Origins of Social Movements. In: Freeman J, Johnson, V (eds.) *Waves of Protest: Social Movements Since the Sixties*. Maryland: Rowman and Littlefield.

Fulford KWM, Morris K, Sadler, J & Stanghellini G (2003) *Nature and Narrative: an introduction to the new philosophy of psychiatry.* Oxford: Oxford University Press.

Furedi F (2003) *Therapy Culture: Cultivating Vulnerability in an Uncertain Age.* London: Routledge.

Fuster M, Morrell I (2007) Techno-Political Tools. In: Wainwright H, Reyes O, Berlinguer M, Dove F, Morrell MF & Subirats J (eds.) *Networked Politics: Rethinking political organisation in an age of movements and networks*. Amsterdam: Transnational Institute. URL: http://www.tni.org/detail_pub.phtml?know_id=39.

Gamble A (1990). The contradictions of Thatcherism. *Occasional papers in politics and contemporary history:* **22**. Salford; Department of Politics and Contemporary History, University of Salford.

Goffman E (1961) *Asylums: Essays on the social situation of mental patients and other inmates.* Harmondsworth: Penguin.

Habermas J (1976) *Legitimation Crisis*. London: Heinemann.

Habermas J (1981) New Social Movements. *Telos* **49**: 33-7.

Hall S (1979) The great moving right show. *Marxism Today*, January: 14-20.

Hall S (1996) Introduction: who needs identity?. In: Hall S, Du Gay P (eds.) *Questions of Cultural Identity*. London: Sage.

Harrison A (1992) *Sheffield NALGO Residential Dispute, 1992.* Sheffield: NALGO.

Hobsbawm E (1978) The forward march of Labour halted. *Marxism Today*, September: 279-286.

James A (2001) *Raising our voices: an account of the hearing voices movement*. Gloucester: Handsell.

Johnstone L (2000) *Users and Abusers of Psychiatry: A Critical Look at Psychiatric Practice*. London: Rotledge.

Kropotkin P (1908) *Mutual Aid: A Factor of Evolution*. London: Heinemann.

Laclau E, Mouffe C (1985) *Hegemony and Socialist Strategy: Towards a radical democratic politics.* London: Verso.

Laclau E (ed) (1994). *The Making of Political Identities*. London & New York: Verso.

Laclau E (2005) *On Populist Reason*. London: Verso.

Laing RD (1967) *The Politics of Experience and the Bird of Paradise*. Harmondsworth: Penguin.

Lecourt D (1975) *Marxism and Epistemology: Bachelard, Canguilhem and Foucault.* London: New Left Books.

Leys C (2001) *Market-driven politics: neo-liberal democracy and the public interest*. London: Verso.

McKeown M, Spandler H, Cresswell M (2008) View Point. *Mental Health Today* March:41.

McKeown M (2008) Alliances in Action: opportunities and threats to solidarity between workers and service users in health and social care disputes. *Alternative Futures, Popular Protest: 13th International Conference* Manchester Metropolitan University.

Marx K (1968) Preface to *A Contribution to a Critique of Political Economy*. In: Marx K, Engels F (1968) *Selected Works*. London: Lawrence & Wishart.

Marx K (1969) Theses on Feuerbach. In: Marx K, Engels F (1969) *K. Marx & F. Engels: Selected Works, Volume One*. Moscow: Progress Publications.

Mental Health Act, 2007 (c. 12). URL: http://www.opsi.gov.uk/acts/acts2007/ukpga_20070012_en_1

Mental Health Alliance (MHA) URL: http://www.mentalhealthalliance.org.uk/aboutus/index.html

Mental Patients Union (MPU) (1973) The need for a mental patients union. URL: http://www.ctono.freeserve.co.uk/id90.htm

National Health Service & Community Care Act, 1990 (c. 19) URL: http://www.opsi.gov.uk/acts/acts1990/ukpga_19900019_en_1

Offe C (1984) *Contradictions of the Welfare State.* London: Hutchinson.

Papacharissi Z (2002) The Virtual Sphere: the Internet as a Public Sphere. *New Media & Society* **4(1):** 9-27.

Parker I, Georgaca E, Harper D, McLaughlin T, Stowell-Smith M (1995) *Deconstructing Psychopathology* . London: Sage.

Pembroke L (1995) National self-harm network. *Openmind*, **73**: 13.

Pilgrim D (2005) Protest and cooption: the voice of mental health service users. In: Bell A, Lindley P (eds) *Beyond the Water Towers: The Unfinished Revolution in Mental Health Services 1985-2005*. London: Sainsbury Centre for Mental Health.

Pilgrim D, Rogers A (2005) Psychiatrists as social engineers: a study of an anti-stigma campaign. *Social Science and Medicine* **61(12**): 2546-56.

Plumb A (1999) New mental health legislation. A lifesaver? Changing paradigm and practice. *Social Work Education* **18(4):** 459-478.

Read J, Haslam N, Sayce L, Davies E (2006) Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavica;* **114 (5)** : 303-318.

Romme M, Escher S (1993). *Accepting Voices*. London: Mind.

Rowbotham S, Segal L, Wainwright H. (1980) *Beyond the Fragments: Feminism and the Making of Socialism.* London: Merlin.

Sedgwick P (1955) Psychopolitics. *Clarion Trinity*: 19-21.

Sedgwick P (1972) R.D. Laing: Self, Symptom and Society. In: Boyers R, Orrill r (eds) *Laing and Anti-Psychiatry.* Harmondworth: Penguin Books.

Sedgwick P (1973) Illness, Mental and Otherwise: All Illnesses Express a Social Judgement. *Hastings Centre Studies* **1(3):** 19-40.

Sedgwick P (1975) The Social Analysis of Schizophrenia. In: van Praag HM (ed) *On the Origin of Schizophrenic Psychoses*. Amsterdam: De Erven Bohn.

Sedgwick P (1981) The Grapes of Roth: Book Review of David Ingleby (ed) (1981) Critical Psychiatry: The Politics of Mental Health. *New Society* 30 April.

Sedgwick P (1982). *Psychopolitics*. London: Pluto Press.

Serge V (1963) *Memoirs of a Revolutionary, 1901-1941*. Oxford: Oxford University Press.

SHA (1989) *'Goodbye to all that…?*' London, Socialist Health Association

Skeggs B (1997) *Formations of class and gender: becoming respectable*. London & Thousand Islands, Calif.: Sage.

Sisters of the Yam (2004) Sisters of the Yam. *ASYLUM: the magazine for democratic psychiatry* **14**:4.

Spandler H (2004) Friend or Foe? Towards a critical assessment of direct payments. *Critical Social Policy* **24(2):**187-209.

Spandler H. (2006) *Asylum to Action: Paddington Day Hospital, Therapeutic Communities and Beyond.* London/Philadelphia: Jessica Kingsley Publishers.

Spandler H (2007) From Social Exclusion to Inclusion? A Critique of the Inclusion Imperative in Mental Health. *Medical Sociology online* **2(2)**: 3-16.

Szasz T. (1974) *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York: Harper & Row.

Szasz T (2004) Reply to Kendell. In: Schaler JA (dd.). *Szasz Under Fire: The Psychiatric Abolitionist Faces His Critics*. Chicago: Open Court.

Szmukler G (2004) Mental health legislation in the era of community care. *Psychiatry* **3(3):** 16-19.

Wainwright H, Reyes O, Berlinguer M, Dove F, Fuster M, Morrell I, Subirats J (eds.) (2007) *Networked Politics*: *Rethinking political organisation in an age of movements and networks*. Amsterdam: Transnational Institute. URL: http://www.tni.org/detail_pub.phtml?know_id=39

Wainwright H. Rethinking political parties. URL: http://www.redpepper.org.uk/article1017.html?var_recherche=rethinking%20political%20parties

Wainwright H. Any Respect Left. URL: http://www.redpepper.org.uk/article689.html

Widgery D (1991) Twice Met: Serge & Sedgwick . *The Victor Serge Centenary Group Newsletter*, January 1991. URL: http://www.petersedgwick.org/articles/biographical/DavidWidgery.html

Wilton T (1995) Madness and Feminism: Bristol Crisis Service for Women. In: Griffin, G. (ed.). *Feminist Activism in the 1990's.* London & Bristol: Taylor & Francis.

Women at the Margins (2004) Women at the Margins: Women and Personality Disorder *ASYLUM: the magazine for democratic psychiatry* **14**:3