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Mad Pride: Reflections on Sociopolitical Identity and Mental Diversity in the Context of Culturally Competent Psychiatric Care

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Although the consumer/survivor/ex-patient (c/s/x) movement has influenced mental health services and human rights discourse for several decades, the broader movement's heterogeneity, and the relevance of its deeper sociopolitical implications to the everyday practice of mental health professionals, have gone largely unexplored in the interdisciplinary psychiatric literature (for exceptions, see Coleman, 2008; Farber, 2012; Lewis, 2006; Morrison, 2005). The purpose of this commentary is to provide a brief overview of the movement to de-pathologize unusual mental states and to discuss implications for mental health nurses and other providers.

The c/s/x movement has historically been best known for its trenchant criticisms of coercive mainstream psychiatric practices and reductionist models of mental illness (Chamberlin, 1978; Coleman, 2008; Morrison, 2005). Various groups and individuals within the movement, however, have moved beyond treatment-centered activism to articulate a broader culture of madness (Church & Reville, 2012; Farber, 2012; Reaume, 2006). These activists have re-claimed the language of madness to challenge the contemporary medical monopoly on the labeling and description of unusual mental states. Activists also have emphasized the connections between madness and art, theater, spirituality, and a valuable sensitivity to individual and collective pain. Mad-identified groups have organized parades and rallies that, like the LGBTQ pride events after which they have often been modeled, function as transgressive, but also productive, displays of difference (e.g., carnivalesque "bed pushes" with protesters in hospital gowns and restraints) that allow socially excluded individuals to visibly commandeer and collectively re-occupy experiences typi-

cally controlled and defined by psychiatrists and other health care professionals (Kates & Belk, 2001). These celebrations of a shared mad culture, like the reclamation of terms such as "craziness" and "lunacy," have helped solidify madness as a culturally meaningful and active sociopolitical minority identity.

What do we mean by an "active sociopolitical minority identity" of madness? "Identity," as cross-disability theorist Siebers (2008) has written, "is not the structure that creates a person's . . . inner essence, but the structure by which that person identifies and becomes identified with a set of social narratives, ideas, myths, values, and types of knowledge" (p. 15). A mad identity is thus not so much about a person's "intrinsic craziness," as the active and thoughtful positioning of the self with respect to dynamic social narratives regarding mental difference and diversity. To "identify" is to actively stake a personally and socially meaningful place in this complex assemblage of social, biological, and environmental forces; an assemblage that importantly includes (and actively grapples with) distress and psychological pain.

It is important to underscore the heterogeneity of perspectives within the mad movement. Some activists, for example, emphasize the categorical differences between madness and normalcy (Estroff, Penn, & Toporek, 2004), while others see madness and normalcy on a continuum. Most individuals within the hearing voices movement seek to de-pathologize voice hearing by normalizing it, and believe that voice hearing exists along continua in otherwise "normal" or "healthy" populations (Corstens, Escher, & Romme, 2009; Honig et al., 1998). In contrast, the hearing voices movement also includes self-identified voice hearers and non-voice hearing supporters who believe that voice hearing can be de-medicalized or de-pathologized without having to be normalized. Likewise, some activists disavow neurological explanations of unusual states, while others, in line with

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the autistic neurodiversity movement, affirm non-pathological neurological differences (Fabris, 2011).

In spite of these differences, activists within the mad movement have consistently made efforts to (1) more rigorously distinguish distress from unusual mental states and (2) re-center the focus of treatment and intervention on the largely psychosocial factors that contribute to distress rather than the unusual experiences (such as voice hearing) in question. For example, researchers involved with the hearing voices movement have drawn on epidemiological research to show that a large number of voice hearers exist who have never been distressed or impaired by their voices (Beavan, Read, & Cartwright, 2011). Further, these individuals have cited research demonstrating that even initially distressful, impairing voices can be transformed over time into neutral or even positive interlocutors through psychosocial interventions and engagement (Corstens, Escher, & Romme, 2009; Romme & Escher, 1993). The implications are that the voices themselves are often not the problem, but rather the voice hearers' relationships with them (Vaughan & Fowler, 2004). The hearing voices movement thus focuses on transforming voice hearers' relationships with their voices, rather than on attempting to eliminate the voices, techniques largely in-line with more mainstream cognitive behavioral techniques (e.g., Morrison, Renton, Dunn, Williams, & Bentall, 2004). Likewise, the mad movement more generally supports interventions that target the social exclusion, poverty, trauma, and grief that contribute to distress and block positive adaptation.

Psychosocial aspects of mental diversity and interventions aimed at coping with distressing experiences are well within the purview of mental health nursing. Mental health nurses and other health care providers can help their clients "integrate" rather than "seal over" psychotic symptoms (McGlashan, Levy, & Carpenter, 1975; Thompson, McGorry, & Harrigan, 2003). Integration promotes the development of more resilient social identities and a sense of collective belonging, the importance of which have been well-documented in the literature (Ghavami, Fingerhut, Peplau, Grant, & Wittig, 2011; Kawachi & Berkman, 2001; Stryker & Burke, 2000; Tajfel, 2010; Thoits, 1999). Beyond promoting individual well-being, active formation of a group identity also inspires political critique and change (Friedman & McAdam, 1992; Polletta & Jasper, 2001; Simon, Trötschel, & Dähne, 2008). An individual who identifies as a c/s/x, for example, is more likely to resist internalizing public stigma and more likely to engage in political activism and protest discriminatory mental health policy changes (Campbell & Deacon, 2006; Crabtree, Haslam, Postmes, & Haslam, 2010).

As has been well-documented in the area of ethnicity and race, key elements of culturally competent care include background awareness, cultural knowledge, and the ability to respond flexibly and sensitively in dialogue with clients (Campinha-Bacote, 2002, 2011; Mahoney, Carlson & Engebretson, 2006). Although not as widely recognized, these same skills apply equally to other sociopolitical minority cultures, including sexual minority communities and individuals with physical and developmental disabilities (Eddey & Robey, 2005). In the context of madness, "background awareness" may involve a basic appreciation of client values associated with a mad identity, and "cultural knowledge" may involve a basic understanding of the history and heterogeneity of the broader c/s/x, mental diversity, and mad pride movements. Clinicians aware of these different perspectives on madness may help their clients explore and negotiate possible social identities, and may even help them understand the broader cultural and political issues associated with their identification processes. Finally, clinicians with "the ability to respond flexibly and sensitively" will suspend their assumptions about the positive or negative valence of their clients' experiences (i.e., assumptions of disease, distress, and impairment), opening up both parties to deeper explorations of the desirable but neglected aspects of clients' experiences and personhood. Clinicians also need to be aware of the impact that their own explanatory frameworks may have (Rose, 1996, 1999, 2001), and endeavor to facilitate individualized processes of meaning-making (Larsen, 2004, 2007), rather than imposing purely clinical or psychiatric interpretations on clients' experiences.

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