Mad or Madisonian?
Deliberation and Psychiatric Disorder

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Abstract

Persons who carry histories of behavioral disorder presumably introduce cognitive diversity into the deliberative setting, but can their deliberative presence ever be unruly? This paper addresses this question by creating a confrontation between several so-called turns of the last decade or two, both political and theoretical. The first turn is towards quiet deliberation in the recovery movement made by persons with the lived experience of psychiatric history. A second turn is away from quiet deliberation among democratic theorists, who now regularly acknowledge that deliberative forms might move beyond rationalistic verbalized argument alone, and towards theater, testimonials, prophecy, stories, imagery and noise. Finally, deliberative theory now is clearly turning towards a consideration of structural encouragements to diversity, a turn supported by evidence derived from various empirical studies of mini-publics. Diverse groups of ordinary citizens can deliberate well; more diversity seems to make better deliberation. But does appealing to diversity always imply making room for the unruly?

...If persons with histories of psychosis are to participate in public deliberations, undertake the transformative labor of reworking cultural templates of disability, they will need practice in voice and standing. (Present-day advocates with their own histories are both exemplary and exceptional in this regard.) Some may require tailored interventions to deal with cognitive impairments. Ex-patients are painfully aware that the real markers of social competence are moral not technical—being recognized as someone who is trustworthy, accountable for her actions, tuned to reciprocity, a person of judgment and good character...For ex-patients to take the further step, to speak out publicly about the casual slights and unthinking dismissals that veterans of psychosis endure, will require grace and courage—to say nothing of facility with language, self-confidence, humor and presence.

—Hopper (2007)

Introduction

This paper considers the deliberative involvements and articulated demands for civil regard and political inclusion made by persons who carry a history of psychiatric diagnosis. The exercise is prompted by two primary motivations. First, historically an excluded, stigmatized and less engaged group, “mad citizens” (terminology I will explain imminently) represent a liminal case for any problem of political enfranchisement. Examples at the borders assist especially with definitional or boundary-defining projects. I believe deliberative theorizing generally is engaged currently in such projects. Second, the accounts and positions I observe directly among advocates and activists, along with published statements I will refer to below, must quell any celebratory impulse about making deliberation more raucous.¹ Related, this evidence about what mad citizens say and do will supply detail to assist the deliberative enterprise of sorting out how far the door is open to “non-cognitive evocation of meanings and symbols that can appeal to actual or imagined shared experiences” (Mansbridge et al. 2010, 67). By their very presence, by their identification as advocates and representatives, mad citizens are evocative. But can they be passionate deliberators?

Perhaps, but the evidence suggests caution. Mad citizens—advocates, consumers,

¹My critique of deliberative exclusions (Sanders 1997) is sometimes interpreted as reflecting such an impulse, though the testimony model sketched then does not advocate raucousness and should contain unruliness. Below I develop the idea of containment, relying on psychoanalytic theory, and consider how it may be a feature of non-cognitive considerations or incompletely theorized deliberative positions.
survivors and ex-patients in the recovery movement—perform deliberation carefully, advancing into politics without expecting immediate recognition but hopeful for a hearing. They exemplify patience. They anticipate some degree of distrust or discrimination on the basis of priors fellow citizens harbor about the relationship of their diagnosis to their ability to participate in civil and political life. They advance nevertheless. As they move forward, however, the precepts that govern their behavior and strategies suggest the influence of Madison at least as much as madness.

What does the recovery movement’s exquisite sensitivity to the requirements of deliberative performance tell us about proposed reforms to the structure of deliberation, especially to the claim that deliberation must make more room for passion? How does the case amplify observations theorists make about various forms of deliberative negotiation, systemic understandings of deliberative democracy, and deliberative virtues? Do mad citizens suggest any remodeling or amendments to deliberative theories and practices? These are the questions to which I hope this paper will suggest some answers.

Overview

I proceed as follows. First, by way of explaining my reference to “mad citizens” I supply a brief review of political movements for persons with psychiatric diagnoses and some contemporary issues regarding services and diagnoses. Second, I will evaluate some recent discussions of widening deliberative participation and utilizing deliberation in health care decision-making, including some calls for more emotion and passion in deliberation. Then, third, I turn to the behavioral evidence on participation by persons with psychiatric diagnoses, demonstrating their capacity for “reasonable” participation, a capacity borne out in accounts from actual engagements with service provision and policy design in states and localities. Fourth, I develop the point that participation by citizens with a psychiatric diagnosis appears more Madisonian than mad. I conclude with three recommendations regarding deliberative theory development. First, in their priority of Madisonian approaches over outrageousness, mad citizens alert us to real limits on the ability of deliberative models to accommodate passionate expression. Second, the idea of containment derived from psychoanalytic theorizing offers a “deliberative virtue,” a complement to ideas about
bridging activity in deliberative settings. Third, the case of participation by mad citizens prompts an observation about power in minipublics, where a relationship may obtain between the presence of fully enfranchised or privileged citizens and the extent to which non-cognitive expression is tolerated or noticed.

Mad citizens: terms and histories

“Mad citizens” are political persons with the lived experience of psychiatric diagnosis and disability. The word mad is purposive and not derogatory. The term reflects both my own political commitments and sympathies and my review of evidence about medical, cultural and diagnostic realities regarding the mental illnesses. As in many other political movements, especially those engaging some form of identity politics, terminology is contested and has evolved to signal specific political stakes in the movement. In advocacy for persons with psychiatric diagnoses, the persons themselves tend to populate a different set of advocacy groups than those who care for or parent the diagnosed person. Not surprisingly, these advocacy groups reflect important differences in their positions on rights protections and self-determination. Still, both self- and family-based advocacy was spurred by dissatisfaction with the psychiatric establishment (Beard 2000).

The recovery movement

Invoking madness in the term “mad citizens” signals alignment with what is now called the recovery movement, featuring advocacy for protection of civil rights of diagnosed persons, and especially rejecting legal treatment mandates in almost all cases. The language is a reappropriation of a disparaging term; it signals a contrast most markedly with the conception of persons with mental illness as psychiatric patients (a now almost completely obsolete term), but also with more widespread or mainstream references to consumers or

2Mandated treatment is strongly advocated by some contemporary political actors: see the positions taken up in legislation currently under consideration sponsored by Ron Barber (D-AZ) and by Tim Murphy (R-PA). http://www.post-gazette.com/opinion/2014/05/16/Mr-Murphy-vs-mental-illness/stories/201405160018; also http://murphy.house.gov/latest-news/what-theyre-saying-barber-bill-wont-help-seriously-mentally-ill/). For a legal overview of involuntary commitment see Parry (1994). For the perspectives of citizens who are the objects of involuntary treatment approaches see Campbell (1997), in addition to cites to Chamberlin and others below.
service recipients.³

Persons with a psychiatric diagnosis are politically involved, though on average at slightly lower rates than are citizens without psychiatric disabilities. Modern political advocacy for persons with a mental illness began in a pronounced way with the founding of the National Association for Mental Health by the ex-patient Clifford Beers in 1909. Distinct from self- or first-person advocacy, family or “third-person” advocacy by relatives and guardians of persons with mental illness emerged in 1979 with the founding of NAMI. In the 1980s these advocates garnered significant federal power (Horwitz 2002; Kolb, Frazier and Sirovatka 2000). NAMI is now (still) arguably the most conventionally politically powerful interest group in the mental illness arena.⁴

By the middle of the twentieth century, mental institutions were widely if not universally acknowledged often to violate human rights and alternatives were sought. In the wake of deinstitutionalization and the civil rights movement in the early 1970s, ex-patients and survivors of psychiatric institutionalization launched the “mental patients’ liberation movement” which advocated for alternatives to traditional psychiatric medicine to manage affliction and worked to secure full political rights for persons diagnosed or labelled with a mental illness. Judi Chamberlin (Chamberlin 1978, 1990) became the foremost enunciator of movement positions. Affiliates of this movement emphasized “mad pride” (Lewis 2006), published the “Madness Network News” (Hirsch et al. 1974) and remain active today.⁵ In contemporary politics the recovery movement supplies a powerful, citizen-based counterpoint to involuntary treatment advocacy. Controversially, it enjoys some support within SAMSHA.⁶ To some observers this may be surprising: “This group of patient actors

³For academic reviews of nomenclature and advocacy positions, see Tomes (2006) and McLean (1995). For discourse analyses of the relationship of terminology and politics from Ireland and North America see Speed (2007) and Réaume (2002). For a perspective on terminology combining experiences as both patient and provider, see Bassman (2001). For a recent account of reappropriating the language of madness with parallels to other rights-based identity politics movements, see Kafai (2013).

⁴Notably, in recent years, approximately since the passage of the Affordable Care Act, NAMI has moved to position itself as a direct advocate for persons with a diagnosis. It has softened its explicit support of mandated treatment. These changes in its advocacy stance are pronounced and require explanation.


⁶Joel Braslow characterizes the recovery movement as now dominant, and asks whether “the recovered
would seem little likely to qualify as a powerful interest group: They suffer from a highly stigmatizing disability, often criticize modern biomedicine, and frequently depend on a fragile network of social services to maintain their independence” (Tomes 2006, 721).

Certified Peer Specialists

Subsequent to Tomes’ remark, in August 2007, the Center for Medicare and Medicaid Services issued guidelines announcing that “as States develop behavioral health models of care under the Medicaid program, they have the option to offer Peer Support services as a component of a comprehensive mental health and substance use service delivery system.” In the last decade, peers have increasingly taken up roles as service providers, with services reimbursable by Medicaid under certain conditions (Eiken and Campbell 2010). Today “Medicaid programs in 30 states and the District of Columbia cover the services of ‘Certified Peer Specialists,’ individuals who have personal experience with behavioral health needs and have completed training and certification to apply that experience to help their clients.”

The involvement of mad citizens as peer providers raises classic issues of grass-roots political organizations moving “onto the terrain of the state” (Reinelt 1995). Today, mad citizens sometimes balance roles as providers within the same systems that they are beholden to and critics of. Since peer services are reimbursed at lower rates than any traditional clinical speciality, the economic incentives for states to increase the ratio of their support for peer specialists compared to traditional psychiatric service providers, will almost certainly increase in the near term. Roles as peer specialists supply mad citizens with an important “place at the table” but also bring new political challenges. It is notable that these dual roles harken back to the recovery movement’s original goals as summarized by Chamberlin: to find alternatives to traditional medicine and to fight for the political

consumer was predicated upon the creation of the psychopharmaceutical consumer,” worrying that despite its apparently radical ideological commitments, recovery shares with welfare reformers “the same neoliberal vision of the individual, his or her responsibilities as a citizen (even if suffering from a mental illness), and antipathy toward the welfare state” (Braslow 2013, 784, 800).

and civil rights of persons with psychiatric disorder.

Constructing Mental Illness

Besides the political position it indicates, another important rationale for utilizing the terminology of madness is to signal skepticism about mental illness itself. There is no doubt that psychic afflictions are real. But there is much doubt about whether many or most of these afflictions are caused by an underlying organic brain disease. No clear biological markers or signs indicating the presence of mental illness or connecting to symptoms have yet been identified. Though psychotropic drugs are widely heralded as reducing symptoms of psychiatric disorder, the mechanisms through which they work are obscure. More important, the harms they are associated with (such as the development of metabolic syndrome) tend to be downplayed, when they should be evaluated directly against the benefits of symptom reduction.\(^8\) For many drugs for many people, the efficacy of symptom reduction erodes over time.

Studies suggest that some severe psychiatric disorders, especially schizophrenia, are inherited and have genetic foundations, though no single gene has been identified to indicate susceptibility, and non-genetic factors substantially modify risk (Allen et al. 2008; Mueser and McGurk 2004). Even in cases where biological foundations of illness are incontrovertible, scholars recommend that services “must emphasize housing, financial assistance and coping skills with daily needs and crises at least as much if not more than they stress medication and therapy” (Horwitz 2002, 215). The category label “mad citizen” may include persons with disorders for which some biological associations have been established, though attempts to associate symptom categories with genetic roots are decidedly controversial. In any event, most psychiatric diagnoses exhibit no such association. The term “mad citizens” aims to appreciate the variety of dysfunctional symptoms associated with psychiatric diagnosis, the exacerbation of even the most “biological” among the diagnoses by environmental factors, and the characterization of disturbing behavior as mad, without making “any etiological commitments” (Gomory, Cohen and Kirk 2013,

\(^8\)Marcia Angell somewhat notoriously made this point in two reviews in the New York Review of Books in summer 2011 (Angell 2011\(a,b\)).
Deliberation and Psychiatric Disorder

Public deliberation is increasingly recommended to address health care issues generally. This rapidly changing policy area engages difficult questions about the distribution of scarce resources and demands some form of public legitimation process. Health policy engages sometimes difficult technical and administrative concerns that even the best informed ordinary citizens cannot be expected to understand well: deliberation might therefore be recommended for its efficiencies in introducing public participants to unfamiliar and difficult topics. Further, minipublics may conveniently be constructed to secure targeted representation of specialized publics. For all these reasons, scholars expect demand for deliberation in health policy to increase (Abelson, Warren and Forest 2012). Summarizing the impulse to consider deliberative procedures to guide health care discussions, Goold et al. remark: “Deliberative procedures offer an opportunity for individuals to assess their own needs and preferences in light of the needs and desires of others. Morally complex decisions may enjoy public legitimacy if they are the result of such fair and public processes” (Goold, Damschroder and Baum 2007, 184).

Public provision for citizens with psychiatric disorder presents issues of technical complexity, low public awareness, and distinctive local needs, so mental health care seems amenable to deliberation. Controversies about perverse incentives and public responsibility for social welfare provision (such as those suggested by the question, will supported housing make people lazy?) also characterize this policy area; deliberation may provide a forum to help citizens evaluate suppositions like these.

But discussions of mental health provision feature two additional, specialized political problems that must be considered as public deliberation’s potential is considered. First, persons who carry psychiatric histories demonstrably face discrimination and stigma, products of fear and ignorance: as a group persons with the lived experience of psychiatric diagnosis present perhaps the last frontier in the civil rights movement. Part of this stigma includes the supposition that persons with a psychiatric diagnosis lack the cognitive capacity for political participation. The political corollary of stigma and discrimination
is disenfranchisement. Persons with a diagnosis enjoy little power to demand adequate funding for services; those who advocate on their behalf enjoy only slightly better success in these demands. In some states still, categorical exclusions of persons who have been involuntarily committed to treatment discourages all mad citizens from voting, making disenfranchisement a direct effect of statutes. Second, historically and currently, the details of treatment and service provision highlight issues of coercion and conformity to political authority to a degree that few if any other health care issues do. The broad summary of these exclusions highlights both material lacks and especially civil disregard and disenfranchisement:

“... individuals with psychiatric disabilities living outside the hospital may be described as in the community, but not of it. They may live in neighborhoods alongside people without disabilities. Their residences may resemble those of their neighbors. Yet many people who are psychiatrically disabled lack socially valued activity, adequate income, personal relationships, recognition and respect from others, and a political voice” (Ware et al. 2007, 469).

Both ideals of justice in deliberative negotiations named by Mansbridge and Warren—“the ideal of including all affected parties and the ideal of equal power in the negotiation” (Warren and Mansbridge 2013, 90)—are challenged if not outright violated by these exclusions. Obviously when mad citizens are categorically excluded from political participation, and also when the history or remnants of these exclusions dampens their participation, deliberations about mental health policy (as well as other matters) are less just. And the issue of coercion, whether directly claimed as a medical necessity or held in abeyance as a possibility, undermines equality of power in the deliberative process.

Provision for mental health—calls for (and the accomplishment of) parity in insurance notwithstanding—is distinct from other forms of health care provision in its implication of political and jurisprudential authority. The main issue here is coercion or mandated treatment, alluded to above. Perhaps related, resisting diagnosis or treatment is a clinical indicator of illness for some psychiatric modalities. Insistence on the rights of ordinary citizens or normal persons may indicate to some a refusal to understand fully that one has a psychiatric diagnosis. Sabin and Daniels (2002) create a similar list of “special challenges” in behavioral health consumer participation.”In the self-help model, the personal and the
political are irreversibly enmeshed” (Bassman 2001, 23). Let us turn to consider how the personalized characteristics of mad citizens may be enmeshed with their potential and real political roles.

**Deliberative roles for mad citizens**

In the domain of mental health, we may, roughly, specify three varieties of deliberation about services. Behavioral health clients may deliberate with clinicians; peers may deliberate with each other about services (or about other topics); mad citizens may deliberate with each other.

**Clients**

For the first, deliberation is a term frequently used, and a process advised, for the therapeutic work between mental health service providers and their clients. At its most mutual, this work is to build together treatment protocols to which both client and provider will adhere; less mutually and more skeptically, this deliberative process might be a persuasive one where a provider secures compliance. This therapeutic deliberation is rarely a purely personal decision process: it is not (only) a mulling over in the client’s own mind, but is always at least dyadic.

Two features of this “therapeutic deliberation” are notable. First, descriptions of it in the mental health literature utilize vocabulary that is absolutely resonant with the vocabulary we see in political theory. As in political deliberation, more than one person is involved: “at least two” who are “partners” according to Schauer et al. (2007, 56). Information is “shared.” Dialogue and consensus may be benchmarks for best practices in the deliberative health care process (Elwyn et al. 2010). Stories and testimonials might have a role in this form of deliberation (Bekker et al. 2013; Elwyn et al. 2006). Perhaps inevitably, in the therapeutic setting governed by the medical model, participatory values compete for priority against the medical outcomes of patient compliance and physician convenience. While shared decision-making can foster and model “mutual respect” this is valued as a “confidence builder for consumers” rather than a just practice (Schauer et al. 2007, 57). Hamann and co-authors’ investigations of shared decision-making in schizophrenia highlight its expedience: their finding that “The intervention studied was
feasible for most patients and did not take up more of the doctor’s time” (Hamann et al. 2006, 265) is representative.

The second notable feature of deliberation construed as shared decision-making is that citizens who want services may very well advocate for it, in contrast to conventional top-down service delivery—though note that a cited disadvantage of shared decision-making is that “consumers who have the expectation that professionals will tell them what to do may become frustrated with the latitude in choosing a course of treatment” (Schauer et al. 2007, 57). For example, in their critique of coercion, Gomory, Cohen and Kirk praise the option in psychiatry where

“the person seeking help and the psychiatrist or mental health practitioner offering it mutually agree to work together to clarify and address the interpersonal or interpersonal difficulties identified by the help seeker. The relationship, which can be terminated by the patient at any time, is based initially on mutual respect or neutrality, and usually involves persuasive discussion” (Gomory, Cohen and Kirk 2013, 291).

Here the therapeutic relationship is constructed to be as egalitarian as possible, with the option of exit stressed (see also Sabin and Daniels (2002)).

Peers

Close to deliberation in the therapeutic dyad, but distinct from it too, both in the recency of its articulation, its explosive recent growth and its general (though sometimes qualified) endorsement by mad citizens, is peer provision, discussed a bit above. Peer provision is rooted in self-help initiatives in the recovery movement, but in the last decade peer provision has “become increasingly incorporated as an occupational category in mental health settings” (Moran et al. 2012, 305). Mental health service settings vary widely; peer roles do as well.

Two features of the peer provider role distinguish it from the therapeutic dyad. First, the “lived experience” of psychiatric disorder gives peers unique wisdom “enabling them to engage other mental health service users on a deep and authentic level.” Second, “peer providers have the opportunity to present the ‘consumer voice,’” an observation that is almost political, because sounding almost like representation (Moran et al. 2012; Sabin and
Daniels 2003, 305). Similarly, the political scientist (and self-identified person with lived experience) Sandra Tanenbaum tells us: “the emphasis on receiving service contributes to consumers’ ability to validate one another’s identity—not as physicians would, with diagnostic criteria and severity indicators, but through the communication that someone has in fact ‘been there’ twice: in the pain and in the system” (Tanenbaum 2014, 923).

But the hazards of co-optation are not remote, and most reimbursement structures require supervision of peers, potentially undermining the independence of their voice. This may be the place to remember the typology developed by Sherry Arnstein in 1969, where the highest of eight rungs of the citizen participation ladder is citizen control, but the lowest rung is “manipulation” and just one rung above it is “therapy.” Arnstein declares “These two rungs describe levels of ‘non-participation’ that have been contrived by some to substitute for genuine participation. Their real objective is not to enable people to participate in planning or conducting programs, but to enable powerholders to ‘educate’ or ‘cure’ the participants (Arnstein 1969, 217).

Still, a point to take away in considering peer provision is that it seems at least on some occasions to structurally or institutionally support a site where political considerations might be shared, where, for example, peers might mull together how to fight discrimination at work or how to register to vote. Thus, perhaps not too optimistically, Tanenbaum reports “consumer-run organizations recognize consumers not just as peers but as leaders and members of a participatory democracy” (Tanenbaum 2014, 923). The statement again features a conjunction of therapeutic and political roles, an ambition that is probably more or less in reach given different structural and institutional arrangements. The conjunction also seems to be the goal of the capabilities approach in community psychiatry, discussed below, which both echoes recommendations about the structure and content of peer provision and also assigns it a therapeutic potential (Hopper and Lincoln 2009).9

9Though note the tone of ambivalence about peer involvement in instituting psychiatric advance directives in Amering, Stastny and Hopper (2005, 251).
Citizens

Which brings us to consider directly a robustly political role in deliberations about politics as well as mental health care by the mad citizens who also consume (and as peers sometimes deliver) services. As summarized by the United Nations in 2006, persons with disabilities, including psychiatric disabilities, have the right to full social and political inclusion. Meaning, according to public health researchers, “that persons with disabilities, including those with mental disorders, have a right to full and effective participation and inclusion in society. Among other things, this includes a housing environment that prevents isolation or segregation from the community, and participation in recreation, cultural activities and political or public life” (Baumgartner and Susser 2013, 30). A classic statement of the ambition here is offered by Liz Sayce: “Inclusion would be a strengthening of the power base of the user/survivor movement and also ensuring that users had a fair chance to move freely across the whole landscape, joining any other power base they chose, from the environmental movement to the political elite” (Sayce 1999, 32).

The fact that citizens utilize services (or deliver them) does not belie their role as “members of the broad public within a jurisdiction or affected by a particular decision” (Kahane et al. 2013, 8) about mental health services, though it may require us to be explicit about self-interest (Mansbridge et al. 2010). Without providing direct advice about how to manage the problem of maintaining robustly political roles for mad citizens, especially in contexts where specialized health policy topics are discussed, Marian Barnes and co-authors articulate the problem at hand: counter publics (such as those mad citizens might make) “have potential to ensure that the development of new collectivities comprising officials and ‘expert’ community members does not result in the loss of the oppositional positions developed outside the official ‘public sphere’ which can be necessary to the pursuit of social justice” (Barnes et al. 2003, 398).

At its most ambitious, the vision of mad citizen engagement styles political participa-

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10 In a new study, Matthew Spitzmueller’s ethnographic work suggests that under Medicaid fee-for-service, programming in a community self-help organization eroded from member-guided processes to standardized and medicalized products (Spitzmueller 2014).
tion not simply as a path to inclusion, but as a counter to the damage done by therapy: “the politicization of the disabled represents an attempt to wrest definitional control of identity from ‘normals’” (Anspach 1979, 768). Similarly, on Athena McLean’s account, “Empowerment was evoked as a means to correct those violations and the pervasive debilitating consequences of their encounters with the mental health system” (McLean 1995, 1053). Here, as in statements from the early recovery movement, empowerment sounds both political and therapeutic notes; protection of civil rights and political involvement is a way to address well-being, both for its direct effects and for secondary control over delivery of services and treatment modalities.

**Political involvement and therapeutic outcomes**

Psychiatric researchers working in a reinvigorated community psychiatry tradition aim now to expand clinical criteria for successful therapeutic interventions to include social integration. Political participation, broadly and subjectively defined, is a component of social integration. In this research trajectory, investigators are extending the emphasis on freedom in Sen’s capabilities approach, developing measures designed to capture the extent that persons with psychiatric histories, including a diagnosis of severe mental illnesses like schizophrenia, by identifying the varieties of civic engagement they value and assessing the degree that services might be structured to enhance their achievement.

As a therapeutic (and moral) intervention, social workers and others working in this community psychiatry tradition stress political engagement as a way to “contribute to the normalization of the individual as a member of the community and as one who is recognized as having the right and the will to fulfill his or her responsibility as a citizen” (Davis 2010, 250). Their perspective differs from anti-stigma campaigns conducted by mental health advocacy organizations, for in this tradition “diluting stigma is less a matter of fixing attitudes than it is one of re-engaging the excluded” (Hopper and Lincoln 2009, 74).

Notably, political involvement is recommended for its therapeutic benefits for mad citizens of all stripes. Hopper recommends it for persons with the serious mental illness of schizophrenia (Hopper 2007). In secondary analysis of federal data I was able to document
a psychologically protective effect of protesting discrimination at work (Sanders 2001). In a recent powerful example, Regina Bateson concludes from her study of crime victims in five countries that not only does emotion drive participation but that motivation is reinforced as victims “are able to reimagine themselves as survivors, organizers, and leaders, reestablishing a sense of control and agency” (Bateson 2012, 572, my italics emphasize the reciprocal causal claim whereby participation has a therapeutic effect).

Both against the claims of the capabilities movement (see, in addition to Hopper cited above, Ware et al. (2007) and Onken et al. (2007)), and against the numerous and various recommendations reviewed above to include persons with psychiatric diagnoses in deliberations as clients, peers and citizens, at least one proponent of the citizens assembly model casually dismisses the possibility of participation for psychiatrized citizens. Kevin O’Leary (mis)characterizes as a “wide cross-section of the community” one that would exclude “the mentally ill, non-citizens, and ex-felons” (O’Leary 2007, 1526-1527). Glibly he also speculates that a citizen’s assembly could “… ask the public to participate in policy making, but with a dramatic difference … the Assembly delegate would be … given the time and resources to study an issue and make an informed judgment … the delegates might be called to examine a foreign policy dilemma, a budget proposal, and legislation to reform the mental health care system.” (O’Leary 2007, 1500, my italics). Both in this law review article and in similar passages in a book on citizens assemblies, O’Leary relies on Dahl to support his restrictions on deliberative participants. Does evidence support O’Leary’s easy exclusion of mad citizens from deliberation, even or especially on mental health policy?

**Deliberative Skill and Psychiatric Diagnosis**

Available evidence about deliberative skills suggests that persons with a psychiatric diagnosis will be, on average, as equipped to participate in deliberation as anyone else. To make this point I first review research on disabilities and voting. Second, I invoke Landemore’s recent claims about the wisdom of collective intelligence.

Recent research assessing the actual functional capacity of persons diagnosed with a mental illness to vote established “that the high scores in this sample are confirmed in
other groups of persons with serious mental illness, it may be appropriate to assume that as a group, persons with serious mental illness do not manifest a substantial incidence of incapacity to vote. This calls into question the legitimacy of criteria embedded in state constitutions, statutes, and regulations, as well as ad hoc efforts that would limit persons with serious mental illness from accessing the polls” (Raad, Karlawish and Appelbaum 2009, 628). Going further on the basis of a direct comparison between persons recovering from a Traumatic Brain Injury and ordinary college students that revealed similar scores on political knowledge and competence tests, a group of investigators recently argued that suffrage laws should primarily be based whether individuals express a desire to vote rather than on categorical restrictions including guardianship status (Link et al. 2012).

Researchers assessing the political involvement of people with disabilities observe both lower levels of participation by persons with psychiatric diagnoses, and also the appearance of a bimodal distribution, where some engaged persons are highly participatory. An early study by John Gastil observed “people with disabilities paid at least as much attention to politics as did the general population, and the relatively small percentage who did become involved in group-based political activities were more active within such organization than were their counterparts in the general population” (Gastil 2000, 600). Along those lines, Lisa Schur and co-authors speculate that stigma and discrimination may join the usual material (SES a la VSB) suspects to depress participation among persons with a psychiatric disability (Schur and Adya 2013). But stigma and discrimination may, however, motivate other individuals to become politically active, as shown by the growth of the disability rights movement (citing Anspach and also Hahn 1985 and Scotch 1988). Similar patterns to those documented by Schur are also observed by Matsubayashi and Ueda (2014) for a longer time period.

For deliberation per se as opposed to voting, Helene Landemore’s recent arguments about the wisdom of the many, specifically the claim that diverse groups are efficient, seems germane. Quite apart from the specialized expertise persons with lived experience will bring, the diversity mad citizens supply is likely to improve the overall reasoning of the group (Mercier and Landemore 2012). More is bound to be smarter, Landemore explains; inclusive deliberative arrangements are not just more fair, but likely better (Landemore
The question remains to be settled: how much emotion—how much expression that is not strictly cognitive—can deliberative theorists see as contributing overall to reasoning in deliberative settings?

**The Expansive Turn: Room for the unruly?**

John Dryzek prefers the term discursive to deliberative democracy because

"deliberation has connotations of calm, reasoned, argument. This is unnecessarily constraining and renders the model vulnerable to those who point out that this sort of gentlemanly discussion is not a good paradigm for democracy. A discursive process connotes something much more expansive in the kinds of communication it allows, including unruly and contentious communication from the margins" (Dryzek 2002, vi).

Many other deliberative democrats similarly have moved away from the narrow priority on reason and the force of the superior argument to expand the deliberative ideal (Mansbridge et al. 2010). Mutual justifiability may proceed on the basis of compelling or persuasive considerations, not just through the force of the better argument. More controversial and less agreed upon, Mansbridge and a large group of deliberative theory co-authors note, is the possibility that the expansion of the deliberative ideal towards mutual justifiability might include more evocative, emotional, enthusiastic introductions into the deliberative forum. It could include passionate expression (Hall 2007; Krause 2008; Sparks 1997).

Though still contested, though clearly not completely incorporated in the more expanded view of deliberation as mutual and non-coercive public justification, the appeal to passion has a number of partisans, some of them quite persuasive. I center here on the turn towards considering the role of passion in deliberation because—the observation that passion and dissent, however unruly, are not irrational, notwithstanding—this turn the seems the one that would, on the face of it, most easily accommodate mad citizens.

Advocates for widened participation in deliberation, especially about topics germane to social movements and relevant to issues of public policy and service delivery, not infrequently recommend that deliberative fora must be expanded or opened or altered to accommodate the new emotional content that service users especially might introduce. For example, Marian Barnes, who regularly advocates this kind of expansion, remarks “It
is also important to consider what kind of spaces might be necessary to encompass the emotional dimension of the experiences of those subject to social policies who seek to draw from personal experience to inform social policy making (Barnes 2008, 462). Mansbridge and co-authors speculate that inclusiveness demands relaxing standards for civility:

“we could imagine using pressure to force the inclusion of marginalized voices or forces new reasons, facts and information into public conversation. In such cases this pressure might make little, or even a negative, contribution to the ethical function of respectful mutual interaction. These cases pose trade-offs within the system. In any given actually existing political situation, levels of civility may have to go down in order for levels of inclusion to go up” (Parkinson and Mansbridge 2012, 19).

Less cautiously, but addressing similar concerns about the justice of deliberative practices, Marian Barnes argues that deliberation must not be reserved for the “dispassionate” public. Her meaning is clear enough. Dispassion would exclude mad citizens, violating the deliberative principle that all actually or potentially affected must be included:

“In a social policy context this means those whose lives are most affected by the nature and quality of welfare services and policies, and by the impact of poor health, impairment, poverty, abuse and other experiences which impact negatively on emotional health ... emotional management should not solely be the responsibility of social movement activists who engage in deliberative forums. Emotion cannot be ruled out of order and public officials cannot claim that good manners dictate that strong feelings be left at the door.” (Barnes 2008, 472, 475).

Barnes’ concerns notwithstanding, observation and reports suggest it is incorrect that the least well off and most disenfranchised are given to the least civility and the most raucous participation. Clearly more systematic study is needed, but my own observations among peer activists and providers in Virginia and other states, as well as published first-person accounts and advice issued by the recovery movement, suggest that raucous or unruly behavior is far from the norm. Consider the account of her work with mental health advocates in Ohio provided by Sandra Tanenbaum. I quote at length:

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11And one case cited in one of her studies
I joined the board’s policy committee and came to appreciate Ohio Advocate’s political presence in the state and at the State House. Huddling over Styrofoam cups of passable coffee, the committee would consider requests, from legislators and bureaucrats, for positions on various policy proposals. These included, during my tenure, outpatient commitment, mental health system reorganization, and the indefinite incarceration of sexual predators in state mental hospitals. State elected officials as well as the cabinet-level director of the Ohio Department of Mental Health regularly appeared at our annual conference—a gathering of hundreds of experienced and occasionally raucous mental health advocates. (One year, an excited psychiatric service dog bit someone.) I attributed this regard to the performance of the Ohio Advocates staff. The CEO was a longtime, knowledgeable, and charismatic mental health activist who lobbied hard and well. Two other staffers, a licensed social worker and attorney respectively, demonstrated to policy makers and the press that mental health consumers could be highly skilled and perfectly reasonable. Of course, Ohio Advocates was not always welcome in the policy community—we were dismissed most notably by the association of mental health provider agencies—but even our detractors acquiesced to the inevitable presence of consumer interests around any table set by the public mental health system (Tanenbaum 2014, 920).

More Madisonian than Mad

Indeed, our data from peer accounts join Tanenbaum’s narrative about her experience with advocacy in Ohio to suggest that participatory citizens with a psychiatric diagnosis are more Madisonian than mad. Despite data limitations, some assumptions seem legitimate on the basis of what we know. First, persons with emotional and cognitive disabilities seem likely to sort into two groups. On the one hand, some citizens decline to participate both for the usual material reasons and perhaps as well due to discouragement from discrimination and stigma; on the other, some are likely more motivated to engage. Importantly, the skewed sample of mad citizens that we observe is likely to be drawn from the second, inspired, more motivated group. Mental health advocacy organizations have no mechanisms or funds to generate large turnout operations for any political purpose. The people who are active in these organizations, the people from whose political behavior
our accounts are drawn, are by definition volunteers who are already motivated. Even if they are spurred by anger or other emotions, their performances in deliberative forums are neither emotional nor unruly.

In this section, I develop the idea that advocacy by mad citizens in the recovery movement is Madisonian. In Virginia, we often begin intellectual projects by seeking inspiration from one of the Founders. Ironically, it appears that James Madison might have been a mad citizen himself. Larry Kramer’s summary (based on biographical work on James Madison by Irving Brant via Ralph Ketchum and Jack Rakove) of Madison’s mood after graduation from Princeton in 1771 assigns the Founder a psychiatric diagnosis.

“Filial duty, not to mention lack of resources, forced a reluctant Madison to return home in April, 1772. The two years that followed were among the lowest of his life. Whatever disease or disability afflicted Madison was at its worst during this period. Historians and biographers have long puzzled over Madison’s illness, though I am inclined (with Irving Brant) to see it as a ‘psychic trauma,’ most likely some form of depression ... Madison suffered greatly from the time he returned to Montpelier until he found his vocation in revolutionary politics several years later” (Kramer 2006, 709).

Further, like mad citizens participating today and not so far removed from the academic claims cited above on behalf of participation’s therapeutic effect, Madison seemed to find a cure for distress in politics. Quoting from Ketcham’s biography: “From the uncertain, introspective, affectedly grave youth he had been in the year after he graduated from college, he had become a man consumed by a cause. He had henceforth his vocation: he was a nation builder” (Ketcham 1971, 67).

**Madison likes filters, pluralism, maybe popular control and liberty**

In *The Voice of the People* (and elsewhere) James Fishkin details the Madisonian virtue of deliberation:

“Deliberation filters the public views in a calm and dispassionate way to arrive at collective solutions to public problems supported by reasons that the representatives have weighed in their discussions together in a manageably small deliberative body ... The filtering of public views arrives at a dispassionate and shared account of the solutions to public problems. It is not motivated by
immediate passions directed against others or interests that seek profit at the expense of others” (Fishkin 2009, 72).

In the back and forth between advocacy offices and legislative hallways, motivated mad citizens, paid staff and student interns, most of whom identify as persons with lived experience, consider problems like expanding Medicaid, training peers to equip them for employment where their services may be reimbursed, and policy initiatives that may, frequently, challenge the civil liberties of persons with psychiatric diagnoses. This is a filtering process. Mad citizen advocates are eminently judicious, planning in almost a scripted way the positions they will present, while also willing—pragmatically—to compromise, as Madison himself was, says Rakove (1997, 37).

In Virginia, five major advocacy groups represent persons with psychiatric trouble, ranging from the state NAMI to VOCAL (Virginia Organization of Consumers Asserting Leadership), a self-help group. Though ideologically diverse, the groups coordinate routinely to develop shared public postures on questions such as supporting Medicaid expansion in Virginia. In the words of one of the more radical group leaders, public conflict must be avoided because it will hurt consumers.

It is tempting to say that almost by definition the movement to involve mad citizens in the political and policy decisions that affect them, through the deliberative and other mechanisms (like meetings of advocacy groups) contributing to deliberative democracy writ large (Chambers 2009, 324) is a movement for popular control. Perhaps Madison’s body of thought itself is not flexible enough to bend into Larry Kramer’s claim that he is in the end a democrat (Kramer 2006). But both the disability rights slogan “nothing about us without us” and the concerted efforts by advocacy groups to address problems of stigma against persons with psychiatric diagnoses, might be sketched as evidence of Madisonian precepts in mad citizen activities. According to Kramer: “To Madison’s way of thinking, the inevitability of popular control gave rise to a corresponding responsibility to refine and improve public deliberations, so as to ensure that the sovereign, controlling public opinion was also reasonable and just” (Kramer 2006, 729).

One critic (Braslow, cited above) characterizes in a not-quite-pejorative way, the recovery movement for being (only) neoliberal now, despite its radical roots. “Recovery
and welfare reform advocates converge most closely on the positive value of independence and their shared abhorrence of dependency. Independence for both recovery and welfare reform is the desired and assumed outcome,” Braslow charges. “‘Empowerment, ‘self-direction,’ and ‘responsibility’ (three of SAMHSAs ten ‘fundamental components of recovery’) describe the aims of welfare reform just as accurately as they enumerate the components of a mental health care system.” To be sure, these Szaszian features appear in stated positions and aims of recovery proponents, including those building up Sen’s capabilities approach for policy design in mental health services. For example, Ware and co-authors endorse “the moral position in which the individual accepts responsibility for the way the world is and ... makes an effort to change it” (Ware et al. 2007, 472). Elsewhere, again, Ware and coauthors prioritize responsibility and accountability (Ware et al. 2008, 29). But the recovery model’s political precepts also include, in Ware and colleagues’ account, the deliberative virtues of empathy and judgment, along with advocacy.

**Sentimental sanctions—bridge or container**

I begin this section in search of the right metaphor with a quotation from Madison. Kramer referenced Federalist 46 to assist his claim for Madison’s commitment to popular control. I want to recall Madison’s words that “the event in every case, should be supposed to depend on the sentiments and sanction of their common constituents” in order to make a different point than that he might have been a democrat. Instead, I want to lay emphasis on three words in this brief sentence, especially the second. By referring to sentiments, to what the people have in common with each other, but especially to the idea of sanction, Madison sketches a process of judicious attention to the views of their fellows. The language of sentiments hints that these views might be less than public reasons, something instead closer to non-cognitive emanations, if not full-blown passions. The common constituents might remind the governments Madison is discussing that they represent constituents, though Madison’s complicated construction might also open the intriguing possibility of the people also having common constituents, that is that citizens help to shape and represent each other. This notion sounds deliberatively appealing, like a process of mutual enunciation. But the best candidate for a deliberative virtue might be Madison’s
reference to sanction. With its promise of approval, agreement or permission, enforcement or authorization, Madison’s word suggests a mechanism for positive containment of deliberative utterances.

The aim here is to try to describe the specific deliberative virtues that mad citizens particularly exemplify. With a few exceptions, we do not see them demanding any right to be unruly. The example, I hope, might contribute to the general deliberative project to entertain different forms of rhetorical disruption, to consider where and when non-cognitive emanations might fit in a general deliberative system (Dryzek 2010, 326, citing Parkinson and Mansbridge). His eye towards sentiment and sanctions suggest that Madison has in mind deliberative skills similar to those Dryzek enumerates when he deploys Putnam to interpret King:

“bridging rhetoric takes seriously the outlooks (ideally, the discursive psychology) of an intended audience that is different in key respects from the speaker—and from the kind of people or discourses the speaker represents ... Bridging rhetoric is hard work for the speaker because he or she must strive to understand and reach an audience whose dispositions are different, as well as hold on to his or her own side ... the idea is to represent a discourse on ones own side that has some compatibility with a discourse on the other side” (Dryzek 2010, 328).

At a number of points above, I have suggested that containment might be another deliberative virtue. The deliberator as container, attuned to the sentiments of fellow citizens, poised to sanction (to hear, to reflect) them, both reaches (as one who bridges) but also perhaps holds in, pulls back and pronounces. Dryzek emphasizes in his discussion of the role of rhetoric how the virtuous deliberator is reflexive and reflective (Dryzek 2010, 329). I find the idea of containment in the work of another democratic theorist, James Glass. In his account of democracy as a political and epistemological defense against psychosis, James Glass describes democratic process in psychoanalytic terms. As a caring parent contains the rage of the split-off, furious infant self, “a resilient democratic culture (one embracing participatory modes of action) will hold or contain the rage of its constituent groups without allowing it to annihilate either the constitutional structures maintaining the community or the respect for rights which allows conflict to flourish without endangering
individuality” (Glass 1995, 21-22). The idea of containment is psychoanalytic, specifically Wilfred Bion’s development of ideas from Melanie Klein. It refers to a parent’s (mother’s) ability to manage the fear, anxiety or distress of the infant, by receiving and reflecting them in a new, detoxified form. The work of containment is reflexive and attentive (and difficult). It also sounds like the work of sanctioning.

Conclusion: Deliberation informed by mad citizens

The foregoing sketch of the political actions of mad citizens, including their rights-based demands for inclusion, their consideration of how to address both legally explicit and more insidious forms of civil disregard, and especially the care they take in attempts to bring their voice to technical policy debates where they are sometimes both an excluded and deeply affected party, seems promising fodder for theory development. I conclude with three suggestions about what we might learn from this case.

First, there is clearly some limit on the flexibility of deliberative structures to incorporate passionate expression. Mad citizens who are committed to civil rights protections and intent on influencing policy design choose their battles carefully and enter public negotiations with great care and control. Absolutely they fear reinforcing stigma and design their approach to reduce the odds that they will be interpreted to be outrageous. Their attention alerts us to the precarious hold that negotiations about mental health policy have on the deliberative ideal of just inclusion of affected parties. I described the attentiveness mad citizens exhibit to shaping their arguments and their reception in broadly Madisonian terms.

Second, I suggested that leaning hard on a particular reading of a bit of what Madison wrote might suggest another, specific, perhaps Madisonian “deliberative virtue.” The idea of containment is clearly derived from psychoanalytic theorizing if not also from Madison. It is a dynamic idea, requiring citizens to read each other and to recognize each other. This deliberative skill is a particularly powerful tool in the hands of the disadvantaged and their advocates; it might be a skill that represents double-consciousness. It is probably a skill that we see those historically disenfranchised disproportionately bringing to deliberations. This idea might be stated in the form of a hypothesis and investigated empirically.
Outrage is more noticeable from some than from others, which is why mad citizens are mostly not outrageous. This suggests a third, probably most important lesson from the case of participation by mad citizens. In deliberations, favorable and unfavorable ratios of fully enfranchised or privileged citizens to partially enfranchised or excluded citizens may be empirically identifiable. That is, favorable ratios may be ones where the license to outrage, or the requirement to be contained, is more evenly shared. What I’m attempting to mark out here is an interaction between general civil and social power of deliberative participants, and the range of cognitions and expressions that become workable deliberative components rather than disregarded distractions. This may be an additional criteria for “equal participation.”

The quotation from Kim Hopper that I cited to open this paper enunciated the ambition for persons with diagnoses of serious mental illness to participate in public deliberations. Hopper stressed the material and skill-based resources required for participation, but also the emotional or psychological capacities that mad citizens need, including being tuned to reciprocity. Politically active mad citizens are exemplars for other citizen deliberators as well as for peers.

References


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