



Beyond biological and social normativity: varieties of norm deviation and the justification for intervention

Andrew Evans¹

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Abstract

The most common theoretical approaches to defining mental disorder are naturalism, normativism, and hybridism. Naturalism and normativism are often portrayed as diametrically opposed, with naturalism grounded in objective science and normativism grounded in social convention and values. Hybridism is seen as a way of combining the two. However, all three approaches share a common feature in that they conceive of mental disorders as deviations from norms. Naturalism concerns biological norms; normativism concerns social norms; and hybridism, both biological and social norms. This raises the following two questions: (a) Are biological and social norms the only sorts of norms that are relevant to considerations of mental disorder? (b) Should addressing norm deviations continue to be a major focus of mental healthcare? This paper introduces several norms that are relevant to mental disorder beyond the biological and social. I argue that mental disorders often deviate from individual, well-being, and regulatory norms. I also consider approaches which question mental healthcare's focus on addressing norm deviations in the first place, including the neurodiversity paradigm, social model of disability, and Mad discourse. Utilizing these critical approaches, I contend that whether mental health intervention is justified depends, in part, on the type of norm deviation being intervened upon.

Keywords Normativity · Norm deviation · Mental disorder · Naturalism · Normativism · Well-being

✉ Andrew Evans
aevans23@nd.edu

¹ Reilly Center for Science, Technology, and Values, University of Notre Dame, 219C O'Shaughnessy Hall, Notre Dame, IN 46556, USA

1 Introduction

A common debate in the philosophy of mental health is how best to conceptualize “mental disorder.” Naturalists ground the concept in an objective, scientific criterion, which is normally understood as biological dysfunction (Boorse, 1976, 1977; Kendell, 1975). In contrast, normativists hold that no such criterion exists, and that our concept of “mental disorder” always depends on social values and conventions (Bolton, 2008; Cooper, 2002; Sedgwick, 1973). So, while naturalism aims to discover disorder in the world, normativism maintains that a condition is only disordered because it is so labeled. Hybridism attempts to combine elements from these two contrasting perspectives. According to this approach, for a condition to count as a mental disorder it must be both socially disvalued *and* biologically dysfunctional (Biturajac & Jurjako, 2022; Murphy, 2006; Wakefield, 1992).

While the differences between these positions are frequently discussed, it is important to note a common feature that they share: each approach conceives of mental disorders as deviations from norms. At first, this claim may seem strange since only one approach is called “normativism.” However, naturalism and hybridism are also grounded in normativity. In Sect. 2, I demonstrate how naturalism concerns biological norms; normativism concerns social norms; and hybridism, both biological and social norms. While I use the terms “naturalism” and “normativism” in accordance with standard practice, it would be more accurate to refer to naturalism as “biological normativism” and normativism as “social normativism.” The key point to emphasize is that all major theories of mental disorder are theories of norm deviation.

In Sect. 3, I examine types of norms relevant to mental disorder, other than biological and social. I introduce the concepts of “individual normativity,” “well-being normativity,” and “regulatory normativity.” A condition deviates from individual norms when it is a marked change from the subject’s baseline, a condition deviates from well-being norms when it makes the person worse off, and a condition deviates from regulatory norms when it inhibits one’s ability to skillfully regulate one’s cognitions and emotions (Leder & Zawadzki, 2023). I argue that mental disorders often deviate from these types of norms, and so they should be considered alongside biological and social normativity.

In Sect. 4, I consider whether mental healthcare is justified in treating norm deviations to begin with. Several contemporary movements have questioned this assumption. Advocates of the neurodiversity paradigm and social model of disability have argued that deviation is not inherently negative, and have called for social changes to accommodate those who diverge from the norm (Chapman, 2019; Kinn, 2016; Walker, 2013). Supporters of Mad Studies and the Mad Pride movement have argued that psychological difference should be celebrated rather than pathologized (Beresford & Russo, 2016; Rashed, 2018). Utilizing these critical approaches, I analyze the five types of norm deviation I have introduced and claim that mental healthcare is least justified in treating biological and social norm deviations, most justified in treating well-being norm deviations, and that cases of individual and regulatory norm deviations tend to be complicated.

2 Mental disorder as norm deviation

Though naturalism has traditionally been discussed in terms of biological dysfunction, this approach can be recast as the claim that mental disorders are deviations from biological norms. Here I follow Schramme (2010) in holding that “the concept of function is a normative one...[it] is normative in the sense that it determines the way a particular trait is supposed to be or a mechanism is supposed to work. Without this kind of normativity there would be no way to talk about dysfunction” (p. 44).¹ Matthewson and Griffiths (2017) contend that there are two versions of biological normativity, one related to biological fitness and the other to evolutionary design. The fitness approach to biological normativity, most famously advanced by Boorse, claims that a disease is present when a body part impairs the organism’s biological fitness, understood in terms of survival and reproduction, in comparison to a relevant reference class (1977; 2014). Kendell (1975) has a similar approach in which he explicitly conceives of disease as norm deviation:

Scadding was the first to recognize the need for a criterion distinguishing between disease and other deviations from the norm that were not matters for medical concerns, and suggested that the crucial issue was whether or not the abnormality placed the individual at a “biological disadvantage.” (Ibid: p. 309).

Kendell elaborates on Scadding’s concept of “biological disadvantage,” defining it as increased mortality or decreased fertility (Ibid: p. 310).

Alternatively, biological normativity can be grounded in what an organism was designed by evolution to do. Wakefield (1992) endorses this sort of approach in his account of mental disorder: a condition is biologically dysfunctional if there is a “failure of a mental mechanism to perform a natural function for which it was designed by evolution” (Ibid: p. 373). For Wakefield, a condition must also be socially disvalued to count as a mental disorder, and so he is considered an advocate of the hybrid approach. However, if we just look at his dysfunction criterion, Wakefield endorses an evolutionary design approach to biological normativity—a second version of naturalism.

For normativism, mental disorders are deviations from social norms. Sedgwick claims that “All departments of nature below the level of mankind [sic.] are exempt both from disease and from treatment—until man intervenes with his own human classifications of disease and treatment” (1973, p. 30). Similarly, Cooper (2002) argues that our conception of disease should be “anthropocentric,” rather than biological (p. 271).² Both approaches hold that what makes a condition a disorder is the fact that society has pathologized it. Bolton’s (2008) approach can also be seen

¹ Similarly, Leder and Zawidzki (2023) hold that “function-based theories commit us to the view that mental health necessarily involves adherence of mental mechanisms to certain ultimate biological norms” (p. 4).

² I should note that, in a recent paper, Cooper (2020) claims that our concept of “mental disorder” shifts over time. She argues that, as things stand, our concept of mental disorder is tied up with social norms, but it is conceivable that the concept could shift to being about biological dysfunctions in the future (Ibid: 142).

as a version of normativism. A major aim of his book *What is Mental Disorder?* is to determine whether mental disorder is grounded in natural or social norms. Ultimately, he argues that naturalist theories fail to pick out those conditions that people actually bring to the clinic, concluding:

It may well be that it would be good if there was a determinate and determinable fact of the matter that would enable us to sort out mental disorder from order ... but things being as they are, there apparently isn't. The problem of boundaries—of what conditions should and should not be in the psychiatric manuals ... has to be—is being—thrashed out among the various stakeholders: consumers, advocates, service purchasers and providers, different kinds of providers, treatment manufacturers and the like. (Bolton, 2008, p. 224)

Here Bolton argues that there is no objective fact that grounds mental disorder, and so what is considered a disorder is a matter of *social negotiation*.

Turning to hybridism, Murphy (2006, 2021) holds that this approach involves two stages. The first stage is agreement that some biological dysfunction is present, and the second stage is a normative judgment that the biological dysfunction is harmful. The identification of biological dysfunction represents biological norm deviation, while the normative judgement of harm represents social norm deviation. The most notable version of hybridism is Wakefield's harmful dysfunction analysis, which holds that a condition is a mental disorder when it is considered harmful by society and involves a mental mechanism failing to perform its evolutionarily designed function (Wakefield, 1992, p. 373). Biturajac and Jurjako (2022) argue that hybridism mitigates the drawbacks of both naturalism and normativism. According to them, naturalism risks pathologizing conditions that are dysfunctional but not bothersome, whereas normativism risks pathologizing non-medical social deviance. Therefore, they argue that only an approach which combines a dysfunction and harm criterion can prevent these potential abuses of psychiatric power (Ibid).

My goal in this section is not to adjudicate the relative strengths and weaknesses of these three approaches. Instead, I aim to highlight that each is a theory of norm deviation.³ In the following sections, I will explore the implications of the fact that we commonly conceive of mental disorders as deviations from biological and/or social norms. Before proceeding, I want to address a possible objection. Some might argue that asserting that all theories of mental disorder are theories of norm deviation overlooks the fact that “norm” is used differently depending on the theory. Normativism conceives of the norm as conformity to societal expectations, Boorse as statistically average contribution to fitness, and Wakefield as adherence to evolutionary design. Given these different interpretations of “norm,” is it misleading to claim that these approaches all conceive of mental disorders as norm deviations? Despite these differences, I hold that each way of using the term “norm” does share an underlying meaning. We can understand “norm” as referring to some standard that a condition either does or does not adhere to. What constitutes this standard can vary but each

³This is similar to Szasz's (1960) claim that “the concept of illness, whether bodily or mental, implies deviation from some clearly defined norm” (p. 114).

theory agrees that mental disorder is a failure to adhere to the standard. This is the similarity between the approaches that I want to emphasize.

3 Other types of normativity relevant to mental disorder

Given the conclusion of the last section, we might wonder: Do mental disorders ever deviate from norms other than biological and social? Consider the following example:

Val is a middle-aged woman who had a fairly average childhood and early adulthood, which were generally free of worries. However, for the last few months, she has been plagued with uncontrollable anxious ruminations. For hours each day, Val can't help but think that she is worthless and that other people see her as incompetent. This leads her to avoid other people, and so she tends to feel lonely and isolated.

For naturalism, Val has a mental disorder if this condition impacts evolutionary fitness or involves a mental mechanism not functioning according to evolutionary design. For normativism, Val has a mental disorder if this condition is pathologized by society. However, Val's condition might deviate from norms that are neither biological nor social in nature.

3.1 Individual normativity

I will refer to another category of norms that mental disorders sometimes deviate from as “individual norms.” We can understand an individual norm as representing a person's baseline, where deviation from that baseline would be considered abnormal. It's often notable when someone is having an experience or behaving in a way that is not typical for them (e.g., feeling sadder than normal or acting unexpectedly paranoid). And in certain areas the DSM references individual norm deviation when discussing mental disorders. For example, when describing bipolar I disorder in children the DSM says:

Since children of the same chronological age may be at different developmental stages, it is difficult to define with precision what is “normal” or “expected” at any given point. Therefore each child should be judged according to his or her own baseline. (APA, 2013, p. 130)

Val's scenario can be understood in these terms. Throughout most of her life, Val worried infrequently. So, the onset of anxiety over the last few months is likely to surprise and concern her and those around her.

Individual norms are distinct from biological and social norms. Val's condition is a deviation from individual norms not because it is biologically dysfunctional or a failure to conform to societal expectations (though it could be those things as well), it is a deviation from individual norms because it is not typical *for her* to feel this much anxiety. We can imagine someone in a different scenario:

Dom is in their mid-twenties and ever since childhood they have worried about existential questions like: Does God exist? Do I really love my family members? Am I a bad person? Now that they are an adult, Dom continues to live with a low-level of anxiety every day.

In contrast to Val, Dom's anxiety does not deviate from individual norms. That is not to say that their condition is not a norm deviation. It is likely that Dom's anxiety deviates from other sorts of norms (perhaps it reduces their evolutionary fitness). But because it is not out of the ordinary for Dom to feel anxious, their condition does not qualify as an individual norm deviation.

To be clear, I am not claiming that atypicality is always pathological. Having new and unexpected emotions and cognitions is a normal part of life, and we wouldn't want to say that this alone constitutes disorder. And atypicality can also go in a positive direction (e.g., feeling calmer than usual). While individual norm deviation should never be equated with pathology, it does serve as a helpful clue that a person might be struggling with something. Because Val's anxiety diverges from her baseline condition it is likely to "raise an alarm bell," prompting an investigation into the cause of this change, which may or may not involve mental healthcare. If Val were to seek out care, the sudden onset and atypicality of her anxiety is relevant information that could aid in treatment planning.

One objection may be that individual normativity implies an unrealistically static notion of health.⁴ After all, it is normal for an individual's psychological states to vary significantly over time. Instead of understanding a person's baseline condition as static, we should see it as a fluctuating range of cognitions/emotions/behaviors that are typical for that person. An individual norm deviation then would be when someone's experience is outside their normal (fluctuating) range of experiences. One might think that a person in this situation is "not being themselves" not because their psychological states are in flux, but because they are in flux in a way that is atypical for them. Returning to Val's case, it might be normal for her to worry occasionally, but the frequency and severity of her current anxiety is notably discordant with her baseline condition.

3.2 Well-being normativity

Another category of norms relevant to mental disorder is "well-being norms." "Well-being" or "welfare" can be taken to mean "the condition of faring or doing well" and this can be equated to someone's "interest" or their "good" (Sumner, 1996, p. 1). Of course, what constitutes "faring well" is hotly debated. Below I provide a way of understanding well-being that can be applied to the mental health context. However, regardless of one's preferred theory of well-being, it is relatively uncontroversial to claim that many symptoms of mental disorders represent a deviation from optimal well-being. Depression is characterized by low mood, a lack of energy, and an inability to perform typical daily tasks, obsessive compulsive and anxiety disorders often

⁴I am grateful to an anonymous reviewer for raising this point.

involve debilitating worry, and schizophrenia can include unpleasant hallucinations and delusions.⁵

Despite the fact that Val's condition deviates from individual norms and Dom's does not, clearly both individuals' conditions deviate from well-being norms, because both involve bothersome anxious ruminations. And this is true regardless of whether their conditions are biologically dysfunctional or pathologized by society. We can contrast Dom and Val's experiences with the that of Maya:

Maya is a young woman who has recently been seeing and hearing things that other people do not. Whenever Maya is alone in her home, she hears voices coming from the vents. Sometimes Maya sees her pet dog from childhood running around outside, despite the fact that the dog died ten years ago. These experiences are new for Maya, but they do not frighten or upset her. In fact, she tends to enjoy hearing the voices and seeing the dog.

Maya's condition is a social norm deviation since her experiences do not adhere to societal expectations. It is also possible that Maya's condition deviates from biological norms. For example, her hallucinations might be caused by a neurological disturbance which diverges from evolutionary design. Additionally, Maya's experiences deviate from individual norms because these visions and voices are new to her. But unlike Val and Dom, Maya's condition is not a well-being norm deviation.

Initially, one may hesitate to agree that Maya's condition does not negatively impact her well-being. In order to argue for this point, I will have to clarify how we should understand "well-being" in the mental health context. A distinction is commonly made between objectivist and subjectivist theories of well-being (Sumner, 1996). Objectivists hold that well-being is independent of the subject's perspective, and these theorists normally provide a list of features that constitute well-being (Fletcher, 2016). In contrast, subjectivists hold that well-being is mind-dependent. There are two major subjectivist approaches, hedonism which grounds well-being in feelings (Gregory, 2016) and desire-fulfillment theory which grounds well-being in getting what one wants (Heathwood, 2016). I do not have space here to argue in depth for any particular theory of well-being but I will contend that, in the mental health context, well-being must be understood in subjectivist terms. Because psychological states are subjective in nature, it would be inappropriate to claim that a psychological condition detracts from well-being without grounding that determination in the individual's own experience. Returning to Maya, while we might initially think that her voices and visions reduce her well-being, it is important to keep in mind that this judgment is grounded in an objectivism which is divorced from her lived experience. Therefore, we must take a subjectivist approach when assessing Maya's well-being.

However, even in accepting a subjectivist perspective, one may still think that Maya's condition reduces her well-being. After all, the scenario described above is only a slice in time. One may assume that Maya's condition will eventually cause

⁵ I should note here that, as was the case for individual norm deviation, I am not equating well-being norm deviation with pathology. Instead, I am highlighting how the conditions we commonly refer to as mental disorders often deviate from well-being norms.

her distress.⁶ I agree that people who experience voices and visions often find them upsetting, and that these experiences can cause major life challenges. Yet in giving the example of Maya, I want to highlight the diverse ways that individuals respond to psychiatric symptoms. The Hearing Voices Network, an organization for people who hear voices and see visions, notes that:

For some, these experiences can be comforting. For example, someone who is lonely may really value a voice that becomes a trusted confidant. A person who has recently lost someone they care about may benefit from talking to them at the end of the day, or smelling their perfume/aftershave. (Hearing Voices Network, n.d.)

Of course, it could be that Maya's condition will eventually cause her distress. Nonetheless, we should be careful not to assume that distress is present just because she is having a psychotic experience. Val and Dom's conditions, on the other hand, clearly deviate from well-being norms.

3.3 Regulatory normativity

A third type of normativity relevant to mental disorder is what I will refer to as "regulatory normativity." Regulatory norms are grounded in an individual's ability to regulate their mental states. Here I am drawing on a recent account from Leder and Zawidzki (2023) which argues that "mental health is skilled metacognitive self-regulation; mental disorder is a failure or breakdown of that skill" (p. 5). By "self-regulation" they mean the ability to "[alter] or [control] one's responses to align with one's goals or standards" (Ibid: p. 8). This ability is metacognitive in the sense that it is "directed at cognitive states" (Ibid). Examples they give of metacognitive self-regulation include the ability to focus one's attention or avoid anxious rumination. Importantly, Leder and Zawidzki note that self-regulation does not require the ability to totally control one's psychological states, and that in fact exerting too much self-control can become problematic (e.g., obsessive compulsive disorder). Instead, they view self-regulation as the skillful ability to manage how one responds to cognitions and emotions (Ibid: pp. 8–9).⁷

The DSM references regulatory norm deviation in certain descriptions of mental disorders. For example, an individual with generalized anxiety disorder "finds it difficult to control the worry" (APA, 2013, p. 222) and major depressive disorder can involve "diminished ability to think or concentrate, or indecisiveness, nearly every day" (Ibid: p. 161). Val and Dom's conditions are clearly regulatory norm deviations, since both individuals have difficulty controlling their anxious ruminations. Whether Maya's condition deviates from regulatory norms though is more difficult to deter-

⁶ I am grateful to an anonymous reviewer for raising this important counterargument.

⁷ It is important for me to note that I do not endorse Leder and Zawidzki's (2023) claim that mental health is equivalent to skilled metacognitive self-regulation. A major claim of my paper is that different types norms are relevant to considerations of mental health and disorder. By introducing their account my aim is only to highlight a version of normativity relevant to mental disorders which is distinct from the other types of normativity I have discussed so far.

mine. As things stand, her hallucinations do not appear to interfere with her ability to control how she responds to her cognitions and emotions. But if these experiences become more intense, or other symptoms develop, Maya's condition may become a regulatory norm deviation.

One may object that the inability to self-regulate is better conceived of as a dysfunction, which would thereby ground regulatory normativity in biological normativity. However, Leder and Zawidzki explicitly reject this interpretation of their account. They claim that "mental health is best conceived of as a quality of persons, not impersonal mechanisms" (Ibid: p. 20). Regulatory norms therefore exist at the psychological level and cannot be reduced to biological norms.⁸ This is demonstrated by the fact that regulatory norm deviation can exist despite the absence of biological norm deviation. For example, if it turns out that depression is evolutionarily adaptive, that will not change the fact that it inhibits one's ability to manage cognitions and emotions (Ibid: pp. 16–17).

3.4 Expanding our conception of norm deviation

The purpose of Sect. 3 was to highlight how mental disorders often deviate from individual, well-being, and regulatory norms. These three types of normativity are not meant to be accounts of mental disorder which could replace naturalism, normativism, or hybridism. Accounts of mental disorder give necessary and sufficient conditions for what psychological conditions count as disorders. I am not claiming that that deviation from individual, well-being, or regulatory norms is in itself pathological and I do not mean to suggest that these types normativity are mutually exclusive. The same condition can deviate from multiple types of norms at once (Val's condition deviates from all three). I am also not arguing that these are the only types of norms relevant to considerations of mental disorder, or that we should ignore deviations from biological or social norms. My claim is only that, when we suspect that a condition falls under mental healthcare's purview, we often consider whether it deviates from the individual's baseline, impacts their well-being, or interferes with their ability to regulate their mind. Given the relevance of these other normative considerations, it is strange that accounts of mental disorder tend to be grounded in biological function and/or societal expectations.

4 Reconsidering the aims of mental healthcare

So far, I have identified norms which tend to be left out of considerations of mental disorder. Yet this inquiry has left unquestioned the assumption that mental healthcare ought to intervene on norm deviations to begin with. In this section, I consider approaches which challenge that assumption: the neurodiversity paradigm, social

⁸One may worry that distinguishing between regulatory and biological normativity implies a commitment to mind-body dualism. However, we must keep in mind that theories like dualism and physicalism are metaphysical rather than normative. It is therefore possible to claim the mental states ultimately reduce to biological states without holding that norms about psychological self-regulation reduce to norms about biological function.

model of disability, and Mad discourse. Utilizing these critical approaches, I argue that mental healthcare is least justified in treating biological and social norm deviations, most justified in treating well-being norm deviations, and that individual and regulatory norm deviations tend to present complex cases.

First elaborated by Walker (2013), the neurodiversity paradigm is represented by the following claims:

1. Neurodiversity—the diversity among minds—is a natural, healthy, and valuable form of human diversity.
2. There is no “normal” or “right” style of the human mind, any more than there is one “normal” or “right” ethnicity, gender, or culture.
3. The social dynamics that manifest in regard to neurodiversity are similar to the social dynamics that manifest in regard to other forms of human diversity (e.g. diversity of race, culture, gender, or sexual orientation). These dynamics include the dynamics of social power relations—the dynamics of social inequality, privilege, and oppression—as well as the dynamics by which diversity, when embraced, acts as a source of creative potential within a group or society. (p. 5)

In sum, the paradigm holds that human minds vary, there exists no ideal that minds ought to conform to, and variation among minds ought to be embraced not suppressed. Though the neurodiversity paradigm was developed by and for the Autistic community, it has also been applied to conditions such as ADHD, dyslexia, dyspraxia, bipolar disorder, and schizophrenia (Chapman, 2019, 2021).

A closely related approach is the social model of disability (Chapman, 2019; Chapman, 2023).⁹ Like the neurodiversity paradigm, the social model claims that divergence from the norm is not inherently negative (Goering, 2015). This model refers to nonstandard conditions as “impairments.” While impairments are neutral, “disability” is conceived of as the harm caused by structural barriers which impact those with impairments (Ibid; Chapman, 2023). The social model therefore advocates for systemic changes which accommodate nonstandard conditions. Though the social model tends to be applied to physical impairments, efforts have been made to include psychological conditions under the model as well. For instance, Kinn (2016) applies the social model to her personal experience of bipolar disorder:

The social model rejects the clinical definition of disability, in the clinical definition I am disabled by my bipolar disorder and other mental health difficulties, in the social model, although I am not denying my internal difficulties, I am largely disabled by society’s excluding and discriminating response to me. (p. 232)

Kinn also notes that applying the social model of disability to mental health is a way to resist pushing people towards “normalization”:

⁹I cite Chapman because they give a helpful explanation of the social model of disability. However, I should note that, while Chapman is influenced by the social model, they recently provided a somewhat different account of disability (2021).

I have observed a tendency for some peer workers where the aspiration is to be “normal,” to be “recovered” or “transformed” and to drop the peer identity as soon as they can ... Without the social model you have nowhere to go but normal ... Normalisation is not only damaging in terms of the failure to embrace the fight for our civil rights, it is directly damaging because it can make internal recovery unsustainable or at the very least a lot more challenging, for most people with long term, fluctuating, mental health difficulties. (Ibid: p. 235)

Here Kinn not only claims that normalization is undesirable, she also acknowledges that given the chronic and ever-changing nature of many mental health conditions, normalization is sometimes not possible.

The Mad Pride movement shares certain similarities with the neurodiversity paradigm and social model of disability. Mad Pride is an international social movement which is part of the larger consumer/survivor/ex-patient (c/s/x) movement (Maughan, 2022; Mulhall, 2011). Though Mad Pride contains diverse viewpoints, broadly speaking it “rejects the language of ‘illness’ and ‘disorder,’ reclaims the term ‘mad,’ and replaces its negative connotations with more positive understandings” (Rashed, 2018, p. 151). That is not to say that Mad Pride considers mental illness to be all positive; psychological distress is recognized (Ibid). Instead, the movement sees Madness as a social identity. In the “Mad Pride” issue of *Asylum* magazine Sen (2011) describes “Mad Culture” as “a celebration of the creativity of mad people, and pride in our unique way of looking at life, our internal world externalized and shared with others without shame, as a valid way of life” (p. 5). From the Mad Pride and c/s/x movements sprung the academic discipline of “Mad Studies.” Beresford and Russo (2015) note that, like Mad Pride, Mad Studies does not have definite boundaries but can be understood as an area of inquiry that challenges traditional approaches to psychological distress and highlights the voices and oppression of ex-patients.

It’s important to acknowledge that these critical approaches come from different perspectives and pursue somewhat different aims. Even within each movement there is a wide variety of diverse, and even conflicting, viewpoints. For example, activists often disagree about the use of psychiatric medications and whether the field of psychiatry should be reformed or abolished. Therefore, we should not hold the movements to any unifying claim or position. Instead, I have introduced these critical approaches because they question the assumption that when a psychological condition deviates from the norm, something has gone wrong and mental healthcare should intervene. That is not to say that the approaches are against treatment altogether. Supporters of the neurodiversity paradigm, social model of disability, and Mad discourse often hold that norm deviation, while not inherently negative, can benefit from support and even advocate for the expansion of such support (Harper, 2011). Instead of viewing the movements as anti-treatment, we should see them as putting pressure on the assumed connection between norm deviation and psychiatric intervention.

With this in mind, we can ask: When (if ever) is mental healthcare justified in treating norm deviations? In order to answer this question I must first clarify what I mean by “justified in treating.” Here, I am not referring to involuntary treatment. There may be cases in which involuntary treatment is appropriate, like when someone poses a serious risk to themselves or others. But considerations like these are outside the

scope of the current paper. Instead, when I say that mental healthcare is “justified in treating” a condition, I mean that this is the sort of condition that mental healthcare ought to be focused on—it falls within the field’s purview. Currently, a major aim of mental healthcare is to better understand and manage deviations from the norm. My goal here is to assess whether and how that aim is defensible.

In order to evaluate the appropriateness of mental healthcare’s focus on norm deviation, we must first get clear on the type of norm deviation in question. For example, when Walker claims that there is no “‘normal’ or ‘right’ style of the human mind” (2013, 5), is she referring to biological function, adherence to social standards, or something else? I do not think there is one clear answer as to what type of norm these critical approaches refer to. Likely, different thinkers have different types of norms in mind. However, it is possible to utilize the conceptual resources introduced in this paper to help assess the appropriateness of intervention. Rather than asking whether norm deviations, in general, should be intervened upon, we can consider this question for each type of norm deviation described above.

There does not appear to be anything inherent to biological norm deviation that justifies treatment. Consider again the example of Maya, who recently began hearing voices and seeing visions. Suppose that Maya’s condition is the result of a neurological disturbance which fails to conform to evolutionary design. While this is a deviation from biological norms, it is not, in itself, a reason for mental healthcare to get involved. And there are many other cases in which biological norm deviations do not call for treatment. For example, it is possible that homosexuality decreases one’s chance of reproducing, thereby statistically reducing evolutionary fitness. That by no means justifies interventions like conversion therapy. Therefore, in the case of biological normativity, skepticism about attempts to correct norm deviation appears to be justified.

Similarly, deviations from social norms are not, in themselves, reason for intervention. Again the example of Maya is instructive. Seeing and hearing things that other people cannot is a violation of social norms. If Maya were to share her experiences with family members or co-workers they would likely be concerned and may advise her to seek treatment. But Mad discourse discourages this knee-jerk response of pathologizing social deviation. Sen emphasizes that an aspect of Mad Culture is, “an acknowledgement that we are reacting to a society that is scared of us” and that the psychiatric system “wants us to conform to an ideal of normality that doesn’t exist anyway” (2011, p. 5). Since Maya enjoys hearing voices and having visions, a negative social reaction is not enough to justify psychiatric involvement. Additionally, associating social norm deviation with intervention can be dangerous, given the history of psychiatric abuses of power. Homosexuality was once in the DSM, and enslaved people that escaped from slaveholders were once considered to be ill with a condition called “drapetomania” (Biturajac & Jurjako, 2022). This demonstrates further that societal disapproval does not justify a treatment response.¹⁰

¹⁰ I should note that in claiming that biological and social norm deviations do not, in themselves, call for mental health intervention, I am not saying that these sorts of norm deviations should never be treated. If Maya’s neurological disturbance or socially disapproved of behavior also causes her distress, then intervention is appropriate. But in cases like this, it is not the biological or social norm deviation that justifies the treatment response, it is the distress.

Things get more complicated when we consider individual and regulatory norm deviation. There do appear to be cases in which personally atypical behavior is cause for concern. For example, Val's sudden onset of anxiety may indicate that treatment could be helpful. However, there are also situations in which individuals are unbothered by deviations from their baseline condition. Maya's case demonstrates that a condition need not fall under the purview of mental healthcare just because it is atypical. Regulatory norm deviations are similarly ambiguous. When someone has trouble controlling their cognitions and emotions we may assume that treatment is called for. For example, since Dom has difficulty managing their anxious ruminations, a friend might suggest they see a psychiatrist. But there are also cases in which individuals desire psychological dysregulation. For example, another contributor to the "Mad Pride" edition of *Asylum* magazine who uses the name "Just Fancied a Rant Clare," says:

We are not just like the Normals. We have experienced something most Normals could never understand. Because Madness is amazing: it is a roller coaster ride of experiences that make absolutely no sense. It is living in a nightmare, it is knowing you are god or the devil, it is wandering through time and space, multiple dimensions abound and how can you tell what is real when all your senses are exploding? (2011, p. 16)

This is an example of someone who finds value in their psychological dysregulation, which may indicate that mental health intervention is inappropriate. So, for both individual and regulatory norm deviations, whether treatment is justified seems to depend on the person and their unique context. While neither type of norm deviation provides an automatic justification for treatment, I would argue they do offer helpful information for making such a determination. Atypicality and psychological dysregulation could be signs of a more serious issue that could benefit from intervention. When such conditions occur, this should prompt the subject to assess whether treatment makes sense for them.

Of the types of norm deviation considered here, perhaps the best justification for mental health intervention is well-being norm deviation. Because a central goal of healthcare is relieving suffering (Callahan, 1999; Cassel, 2004; Svenaeus, 2014), it is natural to think that mental health treatment should be provided in cases where a condition is making someone's life worse. And there is evidence that the critical approaches tend to be less skeptical of interventions on well-being norm deviations. Chapman (2019) explains that neurodiversity theory recognizes that some conditions cause suffering and that the paradigm is committed to minimizing harm. And, in reference to the social model, Goering explains:

People with impairments that involve, for example, fatigue, pain, depression, or chronic illness may want both to overcome social barriers and discrimination that oppress all people with disabilities, and to voice their desire to remove or address the troubling accompaniments of their impairments, through medical or other means. (2015, p. 135)

Additionally, Sen clarifies that valuing Madness does not mean endorsing reduced well-being: “Some may say: ‘Why have pride about suffering distress?’ But it’s not about that. It is pride in our strength to survive that distress and what it teaches us, and not to feel like lesser beings because of it” (2011, p. 5). These caveats seem to indicate that interventions aimed at improving well-being are not the primary target of these critical approaches.

Why is it that well-being norm deviations tend to justify a treatment response? Here it is again helpful to consider the cases of Val, Dom, and Maya. The anxious ruminations that Val and Dom experience cause them significant hardship. When someone is in distress, we have some obligation to help if we are able to. Since the mental health field does have various strategies and tools for reducing distress, it makes sense that it would provide care for Val and Dom. In contrast, while Maya’s condition is norm-transgressing in a variety of ways, it does not make her life worse. If a clinician were to intervene to “correct” Maya’s condition, they would be prioritizing a standard of “normal” that is in conflict with Maya’s own good. Mental healthcare must serve the interests of the client, otherwise it risks paternalism (Knox, 2023; Washington, 2018). This risk is lessened in the cases of Val and Dom because treatment would be grounded in improving their well-being.

I am not arguing that intervention on well-being norm deviation is always justified. There are cases in which a suffering person does not want psychiatric help. For example, Dom may choose to manage their anxiety by joining a yoga class or through mindfulness meditation rather than seeing a therapist.¹¹ There are also cases in which someone finds value in their distress. In the quotation above “Just Fancied a Rant Clare” describes Madness as “living in a nightmare” and also as “amazing” (2011, p. 16). Rather than seeing any one type of norm deviation as always justifying intervention, I want to suggest that we conceptualize the different types of deviation as existing on a continuum. On one end are biological and social norm deviations which never, in themselves, justify a treatment response. Individual and regulatory norm deviations exist in the middle; while they do not always call for intervention, they do prompt an assessment of whether intervention is needed. On the other end of the continuum is well-being norm deviations which often, though not always, justify treatment because these conditions make the subject’s life worse. While this continuum does not give a definite answer as to whether and when mental healthcare should be involved, it does challenge the preconceived notion that biological dysfunction and social abnormality always require intervention, and prompts us to consider more closely other types of norm deviation.

¹¹Along these lines, it is important to note that the subject’s surroundings can impact whether and how their condition deviates from different types of norms. In some cases making changes to one’s socio-material environment is a better way of intervening on a norm deviation than mental health treatment. As I note above, when I say that mental healthcare is “justified in treating” a condition I mean that it is the sort of condition that the field should focus on. That does not mean that treatment is the only, or even best, response. I appreciate an anonymous reviewer for prompting me to consider the significance of the socio-material environment.

5 Conclusion

In this paper I have suggested that we ought to move past the standard focus on biological and social normativity. There are two reasons for this. First, the conditions that we commonly refer to as “mental disorders” often deviate from individual, well-being, and regulatory norms, and these considerations are central to the way we think about psychological distress. Second, there is nothing inherent about biological or social norm deviation that calls for mental health treatment. Therefore, grounding our concept of “mental disorder” in biological and/or social normativity is misguided. Given the malleability of this concept, it may be best to dispense with the term “mental disorder” altogether and instead state explicitly the type of norm deviation we have in mind.¹² At the very least, when we conceive of “mental disorder” we should consider more seriously the relevance of other types of normativity. I have also suggested that well-being norm deviations, in particular, tend to justify mental health intervention. This implies that we ought to pay greater attention to considerations of well-being when we think about the role of mental healthcare.¹³ Psychological distress is common and can be very harmful. Mental health treatment is one tool we have for addressing it.

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¹²Here, I have in mind something akin to Bortolotti’s (2020) point: “I will suggest that the notion of disorder is not central to the project of establishing the status of psychiatry. There is no available notion of disorder which makes sense of the scope of medical practice, mainly because medical attention and medical care are appropriate responses to a variety of problems people experience, independently of whether we identify such problems as pathological” (p. 163).

¹³A recent example of this is Knox’s (2023) account of “psychiatric conditions” which is grounded in considerations of well-being.

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