

Recovery without normalization: It's not necessary to be normal, not even in psychiatry.

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ABSTRACT

In this paper, we argue that there are reasons to believe that an implicit bias for normalcy influences what are considered medically necessary treatments in psychiatry. First, we outline two prima facie reasons to suspect that this is the case. A bias for “the normal” is already documented in disability studies; it is reasonable to suspect that it affects psychiatry too, since psychiatric patients, like disabled people, are often perceived as “weird” by others. Secondly, psychiatry’s explicitly endorsed values of well-being and function are hard to measure directly, which is why we see simpler box-ticking conceptions of recovery used in large research studies. This need not be problematic, but might lead to researchers and clinicians focusing too much on treatments that promote easy-to-measure proxies for recovery, instead of what actually matters to psychiatric patients themselves. Next, we provide examples of treatments and treatment decisions within two areas, – self-injury and psychosis, – which are hard to explain unless we assume that an implicit and harmful normalcy bias is at work. We conclude with some suggestions for clinicians and future research.

1. Introduction: Normalcy And Necessity

Medical necessity is usually treated as a gate-keeping concept; unless a treatment is considered medically necessary, it is not covered by insurance companies or public health care, even if the patient requests it.¹ In this paper, we will focus on the other side of the coin; when treatments are considered necessary and therefore pushed on patients who are reluctant to accept them.

Medical necessity is rarely given a precise definition. However, Sabin and Daniels² identify three implicit views on what medical necessity amounts to in mental health care contexts: it might be considered necessary to restore normal function narrowly understood, restore or improve valuable capabilities somewhat more widely understood, or, even more generally, improve welfare. Absent from this list is normalcy in general; the mental health care system does not explicitly aim to make

people less weird and more normal for normalcy's own sake. Ever since the DSM II's exclusion of ego-syntonic homosexuality from its list of disorders, psychiatry has officially drawn a line between disorder and mere deviance, and defined the former in terms of distress and dysfunction³. Nevertheless, we will argue that psychiatry suffers from a widespread and harmful, but mostly implicit, pro-normalcy bias. Our primary focus is thus on clinicians and their treatment decisions, rather than on the patients and their capacity for decisions-making.

By *normalcy*, in this context, we do not have in mind any explicit medical definition that would apply to mental illness, like the one used in definitions of normal blood pressure: rather, we mean something like statistically common and unremarkable, that which will *not* raise any eyebrows or appear as unusual, scary or weird to people in general. An *implicit* bias is one that influences people's decisions and actions without their awareness.

Our argument is in three parts: Firstly, this problematic normalcy bias is already well documented in disability studies; we argue that it is plausible that it affects psychiatry too. Secondly, research-driven recovery concepts could prompt clinicians to think that recovery *means* meeting a number of easily observable criteria for what is considered socially and culturally normal. Thirdly, and most importantly, there are psychiatric treatment decisions and arguments that are easier to make sense of if we assume that a normalcy bias is at play. We draw on examples from the treatment of self-injury and psychosis to prove our points, and simultaneously show how harmful this bias can be.

Medicine cannot and should not be completely value neutral⁴. Practising medicine does not make sense unless we value health and well-being over sickness and suffering. That said, it remains important that medical practitioners base their decisions on values they endorse on reflection, rather than getting swayed by implicit biases, and that the practice is not more value-laden than institutions in a liberal society should be. Just as it is fine for individual citizens in a liberal democracy to embrace various ideologies, philosophies and religions as the basis of a good life⁵, it is fine for individuals to strive to be normal for normalcy's sake, but this is not something clinicians should press on their patients. This implicit bias may be hidden by talk about functionality, which carries the assumption that only normate bodies and minds, which fit more or less seamlessly into our world and society, are

functional⁶. It is important to listen to people's own assessment of the (dys)function of any problematic behaviour, cognition or emotion.

The love of normalcy and its flip-side, which we shall call *fear of weirdness*, might manifest in many different ways, and we make no attempt in this paper to cover them all. For instance, people sometimes *describe* their mental disorder symptoms in a way that makes them sound more similar to what everyone experiences from time to time than is actually the case. Someone with depersonalisation disorder⁷ might compare it to absent-mindedly letting their thoughts wander on a long bus ride, or other people who feel uncomfortable upon hearing that their friend has a dissociative disorder might make that comparison for them in an attempt to make them seem less weird. Comparing mental disorders to physical illnesses like diabetes is another attempt to describe them in a normalising and non-threatening way⁸. Finally, shutting people off in institutions can be seen as an attempt to make society as a whole seem more “normal”^{9 10}. Nevertheless, in this paper, we will restrict ourselves to cases where clinicians consider it medically necessary to *make* psychiatric patients more normal through treatment, and where they do so even if it clashes with harm-reduction and function-enhancing goals and/or is not wanted by the patient.

2. Lessons From Disability Studies

The problem of medical treatments aimed more at normalisation than personal recovery is widely discussed in the field of disability studies¹¹. Eli Clare¹² writes that *some* illnesses are uncontroversially just that; illnesses that should be cured and eliminated when they appear. No one wants to have bronchitis or pneumonia for its own sake, for instance. However, there are many conditions that are standardly seen as problems to be eliminated as a matter of medical necessity, even though some people living with these conditions disagree. A frequently used example is that of wheelchair users who are fine using wheels instead of feet to get around. Disability activist Harriet McBryde Johnson said that she liked zooming around in her chair, and did not mind at all the curvature of her spine, which doctors had long seen as medically necessary to straighten⁸. Anita Silvers¹³ lists a number of medical interventions up to recent history in which making disabled people closer to “normal” takes precedence over improving well-being and function. For instance, children

born with shortened limbs who were forced to walk slowly, painfully and awkwardly with prostheses instead of doing a faster and more comfortable crawl. There is an assumption at work here that what is statistically normal or average is also normatively desirable¹⁴, and therefore clinicians might mistakenly suppose that such treatments are medically necessary.

The influence of harmful normalcy bias on treatment decisions can be exacerbated when clinicians disregard their patients' own well-being assessments. In disability studies, the "disability paradox" is well established¹⁵. Patients' more positive assessment of their situation is often dismissed as being due to adaptive preferences; disabled people are presumed to adjust to their situation by lowering their expectations. This tendency to dismiss what people say about their own situation could be an even greater danger in psychiatry, where there are increased risks of testimonial injustice¹⁶; clinicians assuming that patients are deficient in their capacity as knowers, and therefore not believing them. This is obviously a danger, if we automatically assume that mental disorders lead to a "lack of insight", an inability to assess one's mental state and behaviour accurately¹⁷. Thus, clinicians may assume that their patients are simply mistaken about their assessment of what is and is not valuable, meaningful or harmless in their lives. If some "abnormal" aspects of their lives seem intuitively horrible and deserving of urgent treatment¹⁰, then it may be better for us to question those intuitions rather than assume that disabled or mentally ill people are mistaken about their assessment of their own lives.

A normalcy bias might prompt clinicians to urge people to "get help" even when they say they are fine, and want only to be left alone. It might also show itself in offering help to people who do think they need help and ask for it, but the help offered as medically necessary is not the kind of help they want, since it aims more at normalising them than easing their suffering and promoting the kind of life they want for themselves.

3. Research-driven Recovery Concepts In Psychiatry And Normalcy Bias

As previously stated, psychiatry explicitly embraces the values of function and well-being. However, scientists sometimes make use of simple box-ticking definitions of "recovery" for research purposes, listing criteria such as having been out of hospital for at least five years,

managing on a low dosage of medication and having normal psychosocial functioning as measured by the Global Assessment of Functioning scale^{18 19}. The GAF scale measures function from 1-100 where 100 is best function; it is focused on symptoms and how they impact a person's ability to work, study, and maintain relationships with others. Other suggested recovery definitions focus more directly on whether the (former) patient can work/study, live independently, and maintain healthy relationships.^{17 20} Regardless, there is a focus on functioning according to common ideas of what an adult person should be able to do, rather than what the psychiatric patient themselves finds most valuable. Well-being is given a smaller, sometimes only indirect, role to play. The concept of recovery is important when we consider medical necessity, as we might assume that treatments which lead to recovery are treatments which are medically necessary.

The idea of "personal recovery" arose as an alternative to such "clinical" ideas among patients/service-users, who wanted to see recovery more as a journey than a fixed outcome, and stressed that factors such as having a sense of hope and meaning in life tend to matter more to the people concerned than, e.g., exactly how long one can stay out of hospital²¹. Such more nebulous recovery conceptions are not without criticism. Service-user organizations and activists have criticised the idea of "personal recovery" and the way it is increasingly endorsed by the mental health care system. Because personal recovery conceptions are more heterogeneous and amorphous than traditional clinical ones, it has been argued, they can be used to cover up the persistent failures of psychiatry to deliver real results²². If we emphasise the possibility of what might be called "in recovery but still sick", this could lead us to help people reduce their expectations, so that they will aim only at having some successes in their lives while continuing to have a mental disorder. Some service users argue that personal recovery has been co-opted to the point that it now differs little from clinical recovery²³.

This paper is not the place to delve deeply into the debate about what should count as "recovery". In some contexts, we might be more interested in people's overall life satisfaction, in others, we might need easy-to-measure criteria. If researchers want to carry out a large-scale study of outcomes for people with a particular diagnosis, or the result of a certain treatment, it might make more sense to look at features like rates of employment or avoiding repeat hospitalisation. Nevertheless, the debate over different recovery conceptions shows us that what ultimately matters to psychiatric patients often

diverges from easy-to-measure recovery conceptions. Unless researchers and clinicians keep in mind that things such as staying out of hospital or having a job are mere imperfect *indicators* of recovery, they might fall prey to a problematic kind of operationalism, that is, they might mistake indicators or proxies of a phenomenon for the phenomenon itself²⁴. Operationalism on part of researchers and clinicians might lead to viewing treatments that aim more at making people tick a number of boxes based on what is considered “normal” than to truly help them as medically necessary.

We have now presented two *prima facie* reasons for suspecting that a normalcy bias might creep into psychiatry and influence which treatments are seen as medically necessary by clinicians, despite the fact that most psychiatrists do not openly embrace the value of normalcy for its own sake; such biases are well-documented in disability studies already, and might be prompted by research-driven recovery concepts. We will now consider two specific cases in which the normal (or less weird) and that which is best for the patient frequently diverge, and where treatment nevertheless often aims at the former. The first of these is self-injury. We do not deny that self-injury is problematic, or that treating people who seek help for their self-injurious behaviour is medically necessary, but the actual treatments provided are frequently more normalising than truly helpful. The second is psychosis. Once again, psychosis frequently involves real suffering on part of the patient, but treatment sometimes aims at normalising at the expense of both the well-being and function of the patient.

4. Treatments And Treatment Decisions That Express A Normalcy Bias

4.1 Non-Suicidal Self-injury

Non-suicidal self-injury (from now on “self-injury”) is defined as the deliberate infliction of tissue damage without suicidal intent. In contemporary Western society behaviours like suicide and self-injury have become associated with mental disorders, and as a result are seen as pathological symptoms^{25 26}. Thus their elimination may be seen not simply as necessary, but *medically* necessary.

Yet, despite its physical harmfulness and disturbing effect on others, self-injury still serves positive functions for many people who practise it ^{27 28}. This can be seen when we consider the most common

motivations for self-injury^{29 30}: managing and reducing overwhelming emotions of distress, disrupting dissociative states, regaining control over one's body, creating a permanent mark through scars, acting against suicidal impulses (hurting oneself satisfies some of the suicidal urge without actually killing oneself), and self-punishment as a route to self-forgiveness. This last one is a seemingly paradoxical case for self-care, but if one believes that there is a genuine need for some form of punishment, this may be preferable to the guilt one would otherwise experience. One of the most consistent themes in self-injury testimonies is that people do not usually self-injure in order to seek attention or to communicate their distress to others²⁷, and aim to alleviate their own distress instead. Therefore self-injury, bad in itself, can hold positive meaning in people's lives. A recent study found that those with greater levels of psychological distress and those who find self-injury useful for alleviating that distress are least likely to try to cease self-injuring³¹. This does not mean that people will enjoy self-injury. There is likely to be significant ambiguity about the behaviour: it is not pleasant, it is a taboo behaviour, there are strong social norms against it.

A worrying possibility is that when we declare that eliminating self-injury is always medically necessary, there is an implicit bias at work in favour of eliminating weirdness and promoting normalcy for its own sake, rather than genuine concern for the welfare and functioning of the patient. Of course, some people may value normalcy for its own sake and welcome interventions which will help them achieve it. One study of self-injury biographies concluded that “[t]he struggle for normalcy is not merely a facade, it is also about wanting normalcy and striving for it, foremost to be(come) like everyone else”³² – but normalcy shouldn't be *pushed* on people.

When we consider that self-injury can be deeply meaningful and may even be a form of self-care, we can then see that some of the alternatives proposed can seem odd. Firstly, some of the commonly suggested alternatives are experienced by patients as self-injurious behaviours in themselves^{33 34}, only they seem normal, or at least less *weird*, to the clinicians suggesting them, as they cause only mild tissue damage (if any) and don't leave lasting marks: snapping a rubber band around one's wrist, holding ice cubes or eating chillies. These alternative forms of self-injury are sensation-proxies³², meaning that they are still meant to be unpleasant or painful. Secondly, there is the issue of power: if someone self-injures to take back control, an authority figure pushing them to do something

unpleasant will once again strip them of control. Thirdly, the alternative may be more unpleasant or painful than another, less acceptable action, such as scratching.

Still, someone who switches from cutting their skin to painful rubber band snapping might appear more normal to others; perhaps they might fully pass as a person without mental health problems when they no longer bear visible marks.³⁵ Passing as “normal” may help someone avoid stigma and discrimination, but hiding pieces of oneself might reinforce feelings that one’s self or identity is damaged³⁶, might be psychologically exhausting, and could lead to more mental health problems in the long run. This is a much-discussed topic in autism studies.³⁷ Being autistic is, of course, very different from having a self-injury problem – autism is a form of neurodiversity, not a problem that needs addressing – but the costs of “masking” (concealing behaviour which indicates a stigmatised identity) might be similar. It would be problematic if we found that the same effect holds for mental disorders and that masking the symptoms of mental illness led to an increase, rather than a reduction in mental illness.

In the cases of both neurodiversity and mental disorders, trying to eliminate “weirdness” reflects a focus on behaviour and appearance rather than the underlying neurology / cognition³⁸. This can leave people with the impression that making the behavioural difference disappear makes the underlying difference or distress disappear too. Thus, if someone cannot be “cured” of self-injuring, then they should learn to pass instead, appearing as normal as possible. This would be a powerful illustration of the normalcy bias and it is important for clinicians to question what their actual motivations are.

It makes sense to suggest socially acceptable forms of self-injury, like snapping a rubber band, if the new behaviour really is less harmful all things considered, and our aim is harm-reduction³⁹ ⁴⁰. If this is the case, we should openly acknowledge that this is in fact what we are doing, rather than pretend that we are *eliminating* self-injurious behaviour, especially as this interpretation conflicts with the light in which many patients see these alternative behaviours. ⁴¹ An honest discussion about harm-reduction can enable shared decision-making and co-creation;⁴² we can empower people by choosing their own, relatively normalised way of self-injuring. Harm-reduction can be a good temporary solution – and sometimes “temporary” means a long period of time. We can reduce harm while keeping in mind that self-injury is a symptom of severe psychological distress, and remember that

our ultimate aim is for patients to practice self-care and manage their emotions through gentler methods.

Harm-reduction is a reasonable motive for adapting self-injurious behaviours, but pushing people who are already experiencing significant psychological distress to change what is helping them for the sake of social appearances of normalcy or to counter our own fear of weirdness is less so. While harm-reduction requires clinicians and patients to work together creatively in order to find meaningful solutions to patients' problems, in fostering passing clinicians more directly aim to teach their patients how to perform normalcy. Thus while the first is an open, dialogical process, the second is based on the clinicians' authority and power to transmit appropriate social norms, while the patient is a passive recipient or at most an imitator with limited possibilities for self-direction. To sum up, sometimes people will value things which we want to eliminate all things considered, but focusing on these behaviours will not solve the underlying problem, and could instead lead to silencing and loss of power and control. Ultimately, we should not focus primarily on the ways in which people deal with their psychological distress, but on what is causing that distress in the first place.

4.2 Psychosis

A normalcy bias might also explain otherwise puzzling judgments about antipsychotic drug treatment that clinicians sometimes make. Such treatment is often considered medically necessary, not only when it is helpful for achieving openly recognized goals of well-being and function, but also when it is detrimental to said goals and unwanted by patients. When this happens, clinicians have departed from the normal understanding of medical necessity in terms of welfare and/or normal *function* (as explained by Sabin and Daniels⁴³). However, such judgments might be explained if we assume that said clinicians suffer from an implicit normalcy bias, which leads them to think of any treatment that might make patients more normal in the sense of being *common* and *unremarkable*, less weird and unsettling, as necessary.

Most jurisdictions require psychiatrists to coercively treat patients who might otherwise harm others or seriously (perhaps even fatally) injure themselves. For the purposes of this discussion, we will set such cases aside. Yet legislation often allows for coercion in a wider array of cases. In Scotland,

patients can be coercively treated not only if they pose a risk to the health or safety of themselves or others, but also if there's a significant risk to the patient's own welfare.⁴⁴ Swedish legislation allows coercion when a patient is deemed in "indispensable need" of psychiatric care.⁴⁵ However, just like "medical necessity" (which presumably comes to the same thing – indispensable and necessary are synonyms), this "indispensable need" remains unspecified.

If a patient is *not* likely to harm others or seriously injure themselves, but resists taking antipsychotics as prescribed, it is rational to compare the positive and negative effects that taking or abstaining from the medication would have on their wellbeing and function, to see what the best (or the least bad) option would be all things considered. If the balance of reasons strongly come down on the side of taking the medication, there is a case to be made for coercion, but the balance will look different for different patients. Some people get symptom relief without serious side effects. However, as much as 30% of all patients might be non-responders to traditional medication, and of those 30-50% are non-responders to the "last resort drug" Clozapine^{46 47}. There is also a substantial patient group for whom antipsychotic medication does suppress symptoms, but at a high cost in terms of negative side effects, such as muscle spasms and tremors, fatigue, cognitive problems, explosive weight gain and related problems like type 2 diabetes.⁴⁸ Of course, discontinuing medication may also come at a steep price in terms of unpleasant symptoms, perhaps a relapse into florid psychosis and hospitalisation.⁴⁹ For some patients, even serious side effects might therefore be worth enduring, while for others, abstention will ultimately be less bad. It is thus *prima facie* puzzling when clinicians judge it medically necessary for *every* psychosis patient to be on antipsychotic medication, even those for whom medication does nothing or is overall detrimental – but we believe that an implicit normalcy bias, and its flipside, an implicit fear of weirdness, might explain these judgments.

Tom Todd provides a first-person account of being forced to endure a detrimental medication regime.⁵⁰ He wanted to quit his antipsychotics because he judged the side effects absolutely horrendous; better to minimise the relapse risk as best he could via medication-free strategies. If and when he still relapsed, he wanted to go back on medication temporarily until his condition stabilised, and then once again taper off. All things considered, he thought, it would be better to have a decent quality of life with a few more relapses than to constantly suffer from the side effects. This is rational prudential reasoning. Nevertheless, the Scottish mental health tribunal judged forced medication to

be necessary for him, stating that this would be *more beneficial for him* – until he finally found a psychiatrist who listened to and agreed with his reasoning, and was allowed to taper off.

Another example of puzzling judgments by clinicians come from Ritunnano, Hampston and Broome.⁵¹ They describe the case of “Harry”, who had many elaborate delusions, but didn’t want to be medicated. His delusions did make him a social outcast and unable to work, but this is true of many medicated psychosis patients as well.⁵² Moreover, being at the centre of several big conspiracies made Harry feel special and important. When asked how he would react if it turned out that his conspiracy beliefs were false, he replied that he would become terribly depressed. In the end, Harry was allowed to remain unmedicated, though he continued to regularly visit psychiatrist Ritunnano. Nevertheless, other clinicians at the clinic considered it necessary to medicate him, with or without his consent. Why? Doing so *might* have enabled him to function better on some measures, but it might also have traumatised him and thrown him deep into depression; the authors of the paper believe that Harry was probably right about how he would react if robbed of his delusions. It is thus hard to find a rational basis for the conviction that it would be medically necessary to medicate Harry against his will; he was not a danger to himself or others, coercive treatment always risks being traumatic for the patient, and there were reasons particular to Harry’s case to suspect that antipsychotics might make him deeply depressed, doing more harm than good.

We believe that a pro-normalcy bias and/or fear of weirdness has the potential to explain these otherwise puzzling judgments. Todd was not exactly *normal* when forcibly medicated, due to the debilitating side effects he suffered. Nevertheless, a sudden burst of florid psychosis and subsequent hospitalisation might seem even weirder and more dramatic to a third party than a state of calm, ongoing suffering. Unmedicated Harry was a strange person indeed, believing and talking about how the whole world revolved around him via a number of complicated conspiracies. If antipsychotic medication could repress his bizarre delusions at the price of making him depressed, at least he would be much more normal, more common and unremarkable.

Some psychiatrists argue that there ought to be no medication-free treatment options for psychosis patients. This might, on the face of it, seem even *more* puzzling. Some might believe that Todd was wrong about his own suffering, or estimate the risk that antipsychotics would make Harry depressed

as fairly low. But it is clearly true that antipsychotics do not work for all patients. Even if future advances in psychopharmacological science will at some point produce medications that help even the most “treatment-resistant” of patients, and do so without intolerable side effects, this is of scant comfort to those who suffer here and now, as there is presently no possible scenario in which all psychosis patients take their medication and are helped by it. If the mental health care system does not include medication-free treatment options for psychosis patients, some will get no help at all.

While some psychiatrists argue against offering medication-free treatment, no one says what should be done with patients who simply do not respond to antipsychotics if there are no alternative options, and strange comparisons abound. Clinical psychologist Richard Bentall writes of his run-in with an anonymous peer reviewer, who claimed that Bentall’s proposed research program of talk therapy (but no drugs) for people deemed to be at risk of psychosis was comparable to the Tuskegee experiments. The alleged similarity was that in both cases, people with a horrible disease would be denied vital medication. Nevertheless, this is an absurd comparison for at least three reasons: Bentall’s research subjects were only *at risk*, antipsychotic treatment has much more variable and uncertain outcomes than giving the right antibiotics to syphilis patients, and, crucially, Bentall’s research subjects would give fully informed consent.⁵³ (His study eventually got funding.) Other questionable comparisons turn up in the BBC’s report on medication-free treatment options in Norwegian psychiatry. They interview critics too, one of whom attempts to illustrate how dangerous unmedicated psychosis patients can be through the story of a man who quit his medication on his own accord to take street drugs instead, and then committed murder – but there is obviously a big difference between doing street drugs on one’s own and attending a medication-free psychiatric treatment program.⁵⁴

Because a substantial portion of psychosis patients are non-responders to antipsychotic medication, and even more patients find the side-effects so hard to deal with that they will quit medication every chance they get, it is irrational to oppose drug-free treatment options as a complement to drug-based ones, and yet people do. We believe that a normalcy bias might explain this. Few people today believe that psychosis patients can turn *normal* through, e.g., talk therapy. The ambitions of drug-free treatment alternatives tend to be more modest; to help the patients find a way to handle their symptoms in such a way that they can live good lives despite them. But people who manage to do that might still seem *too weird*. Boumans et al (2017) interviewed people who managed to live happy

and successful lives with little to no help from the mental health system, with little to no medication, despite psychosis symptoms. Some of their interview subjects explained why they sometimes, e.g., heard voices, by citing their supposed supernatural powers, which is pretty weird according to most people's standards. A medicated psychosis patient, even one who suffers and is incapable of work, study, or having normal relationships with others, might seem more normal by comparison as long as they keep calm and abstain from such bizarre ideas. A "non-responder" who keeps trying one drug after the other while the voices and other symptoms persist might still seem less weird than people interviewed by Boumans' research group who do not even *try* to get rid of their "psychic powers".

5. Conclusion

In this paper we have argued that there are good reasons to presume that there is an implicit bias towards normalcy in which treatments are considered medically necessary in psychiatric practice, similar to that identified in disability studies. This can be harmful to patients because the help clinicians offer may aim at normalisation even at the cost of patient well-being and / or function. We offered two concrete examples. The first of these is self-injury treatment, which might ignore the benefits of self-injury and offer useless or perhaps equally psychologically harmful alternatives instead of treating underlying distress and exploring alternatives to self-injury through shared decision-making. The second is treatment with antipsychotic medication in cases where this is detrimental to the patient's well-being.

This leads us to make the following recommendations for mental health clinicians, educators and researchers:

Clinicians should from time to time examine their own values more deeply and ask themselves if their beliefs about which treatments are medically necessary may have an implicit normalcy bias, or whether their aim is genuinely to improve patient well-being and / or function. In simple terms: does this make things better for the patient, not just in the eyes of others, but by their own lights as well? Do I recommend this treatment for the right reasons, or because I want to suppress symptoms that seem weird and disturb me or others?

It is important to recognise that this is a very difficult task to accomplish on one's own. A useful philosophical concept for further study may be Rini's proleptic, that is forward-looking, account of blame and responsibility.⁵⁵ Rini's aim is to balance, on the one hand, avoiding blame for internalised assumptions which individuals have acquired over a lifetime, and on the other hand, acknowledging the need to do better and holding ourselves and others responsible for doing better when these assumptions and biases prove to be harmful. This approach combines self- and other-forgiveness with recognising a genuine need for change.

Such an approach also acknowledges that in order to counter harmful biases, collective solutions are required⁵⁶. As a result, such self-examination and holding responsible might be best accomplished through education, training and supervision. Therefore, it would be useful for those who educate mental health clinicians to consider how an implicit bias towards normalcy (as opposed to determining medical necessity based on welfare, function, and the patient's own priorities) could be effectively discussed and counteracted at this stage.

In order to support clinicians and educators in these tasks, researchers may want to explore the nuanced ways in which such normalcy biases occur when treatments are prioritised, beyond familiar questions regarding the boundaries of pathological behaviour versus what is merely culturally deviant¹, and how they might impact shared decision-making between patients and clinicians and patients' treatment acceptance.

Finally, researchers interested in medical necessity need to consider not just cases where treatments are withheld, but also cases where treatments are pushed on patients. We would welcome an exploration between the similarities and differences between these two different ways in which determining medical necessity is sometimes problematic.

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