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The skill of mental health
Towards a new theory of mental health and disorder

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Abstract
This paper presents a naturalist skill-based alternative to traditional function-based naturalist theories of mental health and disorder. According to the novel skill view outlined here, mental health is a skilled action of individuals, rather than a question of the functioning of mental mechanisms. Mental disorder is the failure or breakdown of this skill. This skill view of mental health is motivated by focusing on the process of mental healing. This paper argues that, when we start with a focus on how and why individuals heal from mental disorders, we gain a better understanding of what mental health is: the exercise of self-regulatory metacognitive skill.

Keywords
Mental disorder · Mental dysfunction · Mental health · Skill · Stigma

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1 Introduction

While it is generally agreed that mental disorders are a serious problem, there is far less agreement about what the problem actually is. What exactly is *disordered* about mental disorders? The answer is normally situated somewhere between the naturalist/normative divide. Naturalism, roughly, is the position that mental disorders are value-independent, scientifically identifiable and explainable mental phenomena. Normative theories of health conceive of mental disorder as primarily a problem of the meanings attached to behavior and bodies; whether some way of being is a mental disorder is primarily a question of value judgments about

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norm-transgressing behavior. Hybrid theories land somewhere between these poles. Naturalism, or hybrid theories with a necessarily naturalistic component, are the received views in academic psychology and psychiatry. [1] Despite their wide acceptance, there have been significant problems in formulating naturalist views. Notably, it has proven difficult to identify what, exactly, the value-independent basis of mental illnesses is supposed to be.

According to the most influential naturalist approaches, mental disorders are constituted, at least in part, by mental *dysfunctions*. [2] The assumed relationship between function and naturalism is so strong that 'naturalism' is often just (mistakenly) *defined* as a function-based view. [3] Function-based naturalist views posit that mental disorders necessarily involve the failure of some mental mechanism, or mechanisms, to function 'normally'. The most serious difficulty facing these views has been providing an account of normal psychological functioning. The perceived failure of function-based naturalist views to offer a plausible theory of normal mental function has been taken by many to be evidence for the failure of naturalism, full stop, and motivation for the acceptance of normative views. [4] In contrast, this paper argues that mental functions are the wrong point of emphasis in explaining the value-independent nature of mental disorder and that a more plausible naturalist theory can be constructed by grounding the value-independent basis of mental disorder in the concept of skilled action, rather than proper mental function. [5] According to this view, mental health is a type of skilled activity performed by individual persons, not the normal functioning of mental mechanisms. Mental disorder is the failure or breakdown of this skill.

There are at least two desiderata that a theory of mental health should address: (1) it should offer a plausible theory of the boundary between health and disorder, and (2) it should explain how we might know whether any particular mental state falls on one side or the other of this boundary. The motive for the first desideratum is clear: a naturalist theory of mental disorder needs to explain what differentiates disorder from health. The second desideratum is also crucial: a good theory of mental health and disorder should be *useful* and provide us with the means to differentiate between the two. The skill view of mental health provides a naturalist answer to both (1) and (2), while avoiding the more serious metaphysical and epistemic problems of traditional function-based views.

[1] For example, the two primary diagnostic manuals in the West (the DSM-5 and ICD-10) both adopt function-based definitions of 'disorder' with naturalistic components.

[2] For example, see: Wakefield (1992); Boorse (1977); Boorse (2014); American Psychiatric Association (2013); World Health Organization (1992). We use the term 'naturalist' to refer to both 'pure' naturalist views (e.g., Boorse, 1977) and hybrid views with a necessary naturalist component (e.g., Wakefield, 1992).

[3] For example, see: Murphy (2020); Kingma (2013).

[4] E.g.: Cooper (2007); Fulford (1989).

[5] This paper does not directly address the tenability of normative views. The focus here is on whether a strong naturalist view can be developed.

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The structure of the paper is as follows. Section 2 addresses the flaws of traditional function-based views. Section 3 introduces the alternative skill-based naturalist theory of mental health and argues for the conceptual and explanatory superiority of the skill view over function-based naturalist theories. Section 4 addresses potential concerns with grounding the concepts of mental health and disorder in skill rather than function. Section 5 discusses broader theoretical and practical benefits of adopting the skill view of mental health.

2 Mental disorders and mental functions

Mental disorders are traditionally conceptualized in functional terms. For example, both the *Diagnostic and Statistical Manual of Mental Disorders* [5th ed.; *DSM-5*, American Psychiatric Association (2013)], the primary diagnostic manual in North America, and the DSM's international counterpart, the World Health Organization's *International Classification of Diseases* (*ICD-10*, World Health Organization, 1992), adopt function-based conceptions of disorder. The DSM-5 defines mental disorders as follows:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior *that reflects a dysfunction* in the psychological, biological, or developmental processes underlying mental *functioning*. (italics added) (American Psychiatric Association, 2013)

Both the DSM-5 and ICD-10 are intended to serve as theory-neutral diagnostic tools for the identification of symptoms that are jointly sufficient for the diagnosis of a disorder, not to be theories of what disorders are. Theories of mental disorder, on the other hand, are attempts to explain what it is about certain ways of being that makes them healthy, disordered, or benign. And, according to the most influential naturalist views, what differentiates 'genuine' disorders from normal human variation is that the former, but not the latter, are marked by dysfunctions of some kind.

The primary challenge facing function-based naturalist views has been to provide a value-independent account of 'normal' mental functioning. Naturalist solutions to this problem differ in their specifics, but share the common strategy of defining normal mental function as the contribution of a mental part or process to an ultimate biological norm. The most influential candidates for this 'ultimate' norm have been evolutionary design or individual survival and reproduction. [6] According to these 'biological norms' views, the normal function of, e.g., the heart is to pump blood, and not make pounding sounds, because the pumping of blood, but not the production of sound, conforms to some ultimate biological norm (e.g., it is what the heart was designed by natural selection to do, it contributes to the

[6] The touchstones for the evolutionary and longevity/reproduction views are Wakefield (1992) and Boorse (1977), respectively.

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ultimate end-goals of individual survival and reproduction, or it conforms to some other biological norm). The problems with function-based views are well known. [7] Most notably, dysfunction appears to be neither necessary nor sufficient for the presence of a mental disorder.

Dysfunction is likely not sufficient for disorder. For example, depending upon what theory of 'normal' function one adopts, exclusive homosexuality, asexuality, and a lack of desire to reproduce may all be considered 'dysfunctions' (because of their effects on reproduction), but they should not be considered disorders (e.g., Cooper, 2007). Defenders of the sufficiency view have responded to this concern by arguing that we should divorce our theory of disorder from any normative judgments we have about experiencing a disorder or being labeled as having a disorder (e.g., Boorse, 2014). However, even if we accept that the concept of disorder should be value-neutral, we should still be judging a theory of disorder based on the plausibility of its extensional assignments. The sufficiency view is not incoherent, but it is highly implausible.

Dysfunction is also likely not necessary for disorder. For example, it is an open empirical question whether behaviors and mental phenomena normally considered to be 'disordered', such as the phenomena associated with depression, anxiety, and schizophrenia, are in fact the result of dysfunctioning mental mechanisms rather than being the consequences of mechanisms functioning as they normally should. [8] Depression, for example, is variously hypothesized to be the result of *dys*-functioning mental mechanisms that lead to 'interlocked' cognitive-affective cycles of mental processing (Teasdale & Barnard, 1993), the product of *normally* functioning mental mechanisms that lead to an increase in critical ruminative thought (Andrews & Thomson, 2009), the result of *dys*-functioning mental mechanisms that produce negatively valenced loss-based cognitions (Beck & Alford, 2009), or the result of *normally* functioning mental processes that socially signal the need for assistance (Watson & Andrews, 2002). And we see similar variations in the hypothesized role of 'dysfunction' for other paradigmatic disorders such as generalized anxiety disorder, schizophrenia, and bipolar disorder. The take-away point here is not that each of these theories is equally as plausible, nor is it that we are never able to make plausible inferences about the existence or functions of mental mechanisms. Rather, the point is that if we accept dysfunction as the grounding of our concept of disorder, then we must accept that it is an open question whether some paradigmatic disorders are in fact disorders.

Function-based theories commit us to the view that mental health necessarily involves the adherence of mental mechanisms to certain ultimate biological norms. This focus on biological norms (e.g., evolutionary design or individual survival and reproduction), while potentially establishing a value-free foundation for the concept of disorder, also leads to a potentially massively revisionary conception

[7] The literature here is extensive. E.g.: Cooper (2007); Kingma (2014).

[8] This concern has been raised by a number of authors (e.g., Lilienfeld & Marino, 1995; Woolfolk, 1999).

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of mental health.[9] Dysfunction views are committed to the claim that it is an open (though possibly unanswerable) empirical question whether any postulated 'mental disorder' is in fact the result of a dysfunctioning mental mechanism, and thus a genuine mental disorder. It is possible that paradigmatic disorders such as depression, anxiety, and phobias may turn out *not* to be mental disorders, but rather products of *healthy* minds dealing with mere problems of living. While, on the other hand, behavior not commonly considered to be a product of unhealthy minds, such as homosexuality, a lack of desire to reproduce, and the engagement in dangerous 'thrill-seeking' activities, may in fact be mental disorders if it turns out that they are the result of dysfunctioning mental mechanisms.[10] This is not incoherent, but it is highly counterintuitive.

The use of dysfunction, then, to ground the value-neutral basis of mental disorders appears unsuccessful. If function-based theories of health make it possible that depression and anxiety are not mental disorders, but homosexuality is, then this gives us good reason to think that the presence or absence of mental dysfunctions is not necessarily related to the concept of mental health. That the entailments of function-based views may be so revisionary and contrary to common folk conceptions of disorder is *prima facie* evidence that something has gone wrong with the focus on dysfunctions to explain the distinction between mental health and disorder, and gives us reason to search for a more plausible naturalist conception of mental health.

The problem is this: despite their prominence, there have been serious problems in formulating a naturalist conception of mental disorder. Dysfunction-based naturalist views are not incoherent but they are seriously flawed. These flaws can either be accepted as part of the cost of formulating a naturalist theory, or taken as evidence for the failure of naturalism. In contrast, this paper argues that a more plausible naturalist view of health can be constructed if we reorient the dialectic away from the concept of normal function and focus instead on the skills constitutive of mental health. Skill, rather than function, can provide the objective basis for a naturalist theory of mental disorder.

The new naturalist theory of mental health outlined here argues that mental health is best conceived of as a skill. More specifically, this paper argues that mental health is skilled metacognitive self-regulation; mental disorder is a failure or breakdown of this skill. The skill view of mental health provides a naturalist framework for the scientific study and treatment of mental disorders that avoids

[9] Murphy (2006) makes a similar point.

[10] Note that while function-based views agree that mental dysfunctions are necessary for disorders, they differ over whether they are also sufficient. 'Pure' function-based views posit that the presence of a mental dysfunction is both necessary and sufficient for disorder. 'Hybrid' views posit that dysfunction is necessary, but not sufficient for disorder; disorders must also be judged to be 'harmful' (with the 'harm' criterion being a value-based claim that varies between cultures and value systems). So, for example, the 'pathological' status of homosexuality depends upon its status as a dysfunction (for both pure and hybrid views) and whether it is judged to be harmful in a given value-system (for hybrid views only).

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the epistemological and conceptual failings of traditional function-based views. The focus on skilled action, rather than adherence to biological norms, allows for a flexible theory of health that avoids pathologizing normal human difference while also providing a non-revisionary accounting of paradigmatic mental disorders.

3 The skill of mental health

The skill view of mental health makes the following two claims:

1: Mental health is skilled metacognitive self-regulation.

2: Mental disorder is a failure or breakdown of this skill.

Sections 3.1-3.2 outline theory-neutral naturalist accounts of skilled action and self-regulation. Sections 3.3-3.4 will address the skill view's claims in order.

3.1 The value-neutrality of skill

The term 'skill' has a number of common uses. 'Skill' can refer to a particular type of possible action (e.g., the skill of playing tennis), to a way of acting (e.g., being a skilled, as opposed to unskilled, tennis server), and to expertise in action (e.g., being a skilled, as opposed to novice, tennis player). This paper is concerned only with the first two conceptions of skill. The focus here is on what differentiates skilled from unskilled action, not what differentiates low skill from high skill, or skill from expertise.

This paper adopts a theory-neutral conception of skill: minimally, to be skilled at ϕ-ing requires that one possesses the ability to ϕ intelligently.[11] Both 'ability' and 'intelligence' can be disambiguated. Following Mele (2003), we can distinguish between two senses of 'ability':[12]

Ability$_1$: An agent is able to ϕ, given appropriate background conditions.

Ability$_2$: An agent is able to ϕ *and* has the appropriate background conditions satisfied to successfully ϕ.

The distinction is straightforward. There are many things an agent may be generally able$_1$ to do (such as play tennis), but that she is at some point in time unable$_2$ to do because of something that masks this ability$_1$ (such as a sprained ankle). Skill at ϕ-ing necessarily requires the ability$_1$ to ϕ. There is no scenario in which an agent is skilled at performing some action, yet there is no possible circumstance in which she is able$_1$ to do so. For example, whatever the specifics are of a theory of skill, a person cannot be a skilled tennis player if she is not now, nor ever was, able$_1$ to play tennis. However, possessing the ability$_1$ to ϕ does not entail that one is always *able*$_2$ to ϕ. A skilled tennis server is able$_1$ to strike tennis balls into the

[11] This definition is consistent with both Intellectualist (e.g., Stanley & Williamson, 2017) and Non-Intellectualist (e.g., Ryle, 1949) theories of skill.

[12] Mele (2003) does not use this exact formulation.

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service area, *only* given that certain background conditions are met (e.g., that she has access to a racket, ball, is free from injury, and so on). The lack of a racket or a sprained ankle might render her unable$_2$ to play tennis on any given day, without necessarily affecting her ability$_1$, or skill, to play. Skills may diminish after long periods of being unable$_2$ to perform, but one's ability$_1$ to ϕ is not necessarily dependent upon whether one is able$_2$ to ϕ at any given time. A skilled *action*, on the other hand, does require that one is able$_2$ to ϕ. For example, skilled tennis service requires that one is both able$_1$ to strike balls into the opposing service box, *and* that the enabling conditions are met for her to do so successfully.

Skill may require ability$_1$, but ability$_1$ is not sufficient for the presence of skill. A person learning to strike tennis balls may be able$_1$ to regularly propel balls into the opposing playing area if the balls are carefully teed up, but this activity is not necessarily a skilled act. The 'intelligence' constraint is meant to distinguish skill from reflexive, lucky, or merely successful action. Theories of skill differ greatly over how to specify the intelligence clause, but there is broad agreement that, minimally, 'intelligence' requires the ability$_1$ to adapt, learn, and intentionally modify one's behavior in response to novel stimuli.[13] The new tennis player learning to strike a ball off a tee lacks the ability$_1$ (at least at that moment) to intentionally modify their behaviors to adapt to new problems such as a change in ball trajectory, speed, or spin. A skilled tennis player, on the other hand, would be able$_1$ to learn from, and adapt to, different shots, opponents, and physical constraints. Theories of skill differ over what else, if anything, is needed in addition to intelligence and ability$_1$ to explain skill. As with our analysis of function-based views, we need not take a position here. The aim of this paper is not to argue for a particular theory of skill, but rather to examine whether the concept of skill (given the above constraints) can ground a naturalist theory of mental health.

Importantly, the concept of skilled action can be formulated in value-independent terms. Judgments of how *well* one performs some task and how well one modifies one's behavior clearly *are* value-judgements. The judgment of skill as *expertise* also appears to be value-laden (insofar as whether or not some action is done expertly varies depending upon the standards set). In contrast, whether an agent is able$_2$ to intelligently ϕ is not, or at least need not be, a value judgment. For example, metaphysical theories of ability commonly take the conditional form: an agent is able$_2$ to ϕ if she would ϕ if she tried (Maier, 2021). Theories differ over how to best specify these enabling conditions, but these theoretical differences needn't be differences in *value* (just as metaphysical disputes over the existence of midsize objects are not necessarily disputes over values). Similarly, theories of the metaphysics of intelligence generally are attempts to precisify some cognitive faculty that things like humans have, and things like modern computers currently lack. There is certainly room for values to enter into the answer to this question, but there is no necessary reason that this need be the case. More generally, insofar as a value-independent metaphysics is possible, the

[13]For example, both Stanley & Williamson (2017) and Ryle (1949) adopt this view.

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metaphysics of skill, like the metaphysics of function, poses no unique problem that necessitates a value-based theory.

There are, of course, *epistemic* challenges in identifying when any particular action is skilled. Section 3.4 will address these epistemic constraints, and show that they compare favorably to those facing function-based views. Sections 3.2 and 3.3 will outline theoretical commitments of the skill-based view of mental health.

3.2 Skill and self-regulation

Claim (1), defended in the next section, states that mental health is skilled metacognitive self-regulation. 'Self-regulation', here, refers to the process of altering or controlling one's responses to align with one's goals or standards (Baumeister et al., 1993; Fujita, 2011). The absence of self-regulation is met by purely automatic cognition, emotion, and behavior based on 'learning, habit, inclination, or even innate tendencies (Baumeister et al., 1994).[14] Everyday examples of self-regulation include regulating emotional responses to perceived losses or gains (e.g., inhibiting the experience of intense emotions), regulating cognitions (e.g., avoiding ruminative patterns of thought, or conversely, focusing one's attention despite distractors), and regulating impulses (e.g., in regard to food, drink, or self-expression). Psychological accounts of self-regulation are traditionally focused on the ability$_2$ to regulate one's responses towards some ultimate distal goal or idealized conception of self (Carver & Scheier, 1982). This paper adopts a more restricted conception of self-regulation; we are interested in the ability$_2$ to regulate one's responses to one's *immediate* willings. We are not concerned here with the notion of the idealized self or in identifying individuals' ultimate goals. Rather, the focus is on whether one is *able$_2$,* at any given time, to skillfully regulate one's responses to whatever standard one wills.

There is also an important difference between regulating one's *responses* and completely *controlling* one's mental life. Self-regulating involves the 'overriding, stopping, modifying, or otherwise changing' of one's responses to exogenously and endogenously generated stimuli (Rawn & Vohs, 2011). This skill can, but need not, involve controlling the generation of mental content. Completely controlling the generation of mental content would require the ability$_2$ to only think, feel, and desire what one wills (e.g., only thinking pleasant thoughts and experiencing positive emotions). Self-regulation does not require the (possibly superhuman) ability$_2$ to completely control the generation of one's cognitions and emotions. Regulatory strategies may *include* the attempt to control the generation of mental content (e.g., by avoiding situational triggers), but attempts to control content can also be part of the *problem* that requires regulation (as can be the case with obsessive disor-

[14] The skill view does not claim that all instances of self-regulation must be conscious and effortful. It is generally accepted that self-regulation may involve automatic processes (though there is debate about how much) (e.g., Vohs & Baumeister, 2004). This paper uses 'self-regulation' to refer to self-regulatory processes (both 'automatic' and 'conscious') that are directed at regulating one's responses towards some self-initiated goal (Duckworth et al., 2016).

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ders). Automatic and unwanted thoughts, emotions, and urges are a normal part of mental functioning, and the failure to completely control the content of one's mental life is not necessarily a failure of self-regulation. Failures of self-regulation involve inability$_2$ to regulate how one *responds* to these thoughts, emotions, and life-events.

3.3 Skill and mental health

Claim (1) states that mental health is skilled metacognitive self-regulation. The term 'skilled' in both claims (1) and (2) refers to the *exercise* of the skill of self-regulation. Mental health requires not just the possession of the skill to self-regulate, but also that the appropriate enabling conditions are met in order to be able$_2$ to exercise this skill. According to this conception of health, mental health is a skilled way of acting, rather than the proper functioning of mental parts.

The term 'metacognitive' in claim (1) refers to the fact that the skillful self-regulation exercised in mental health is directed at cognitive states, broadly construed, including beliefs, desires, and emotions. As explained in Section 3.2, self-regulation involves the ability$_2$ to regulate one's responses to thoughts, emotions, and life-events, and these responses are, in the first instance, other cognitive states. Even if behavioral responses are also in the scope of such self-regulation, such behavioral responses are products of prior cognitive responses, and cannot be skillfully regulated without the skillful regulation of the latter. Hence, the kind of skillful self-regulation relevant to mental health is inevitably metacognitive. Unlike embodied skills, like athletics or musicianship, or intellectual skills, like chess or advanced mathematics, both of which *make use of* cognitive states and capacities, metacognitive skills, in addition to making use of cognitive states and capacities, are also *directed at* cognitive states and capacities. Their domain is cognition, unlike embodied skills, the domains of which typically involve some socially constituted, bodily activity, or intellectual skills, the domains of which are more abstract, like chess or mathematics. Hence, the skills of self-regulation relevant here are aptly called 'metacognitive'.

The skill view of mental health is motivated by focusing on the process of mental *healing*. Theories of mental health are typically developed without an explicit focus on the process of mental healing. On the one hand, this is understandable. Theories of health are normally considered to be the basis from which we can determine what healing is. Health is logically prior to healing; if we don't know what health is, then we don't know what healing is (i.e., 'healing' is healing from *what* and to *what*?). On the other hand, the traditional disregard of mental healing in the construction of theories of mental health has missed a significant source of data from which to build a theory. Theories of mental health and disorder are not (or at least should not be) developed a priori; they begin with observations about mental phenomena and human behavior (e.g., the 'symptoms' of mental disorders) and

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attempt to explain what, if anything, differentiates health from disorder. These observations should include, as important components, what happens when individuals mentally heal.[15] In order to figure out what has 'gone wrong', theories of health and disorder should look to what happens when things go back to 'being right'.

In support of (1), we should first notice that mental healing and health necessarily *involves* self-regulation. This is made clear if we consider the process of mental healing. Regardless of whether disorders are conceived of as problems of natural function or of value, one of the primary end-goals of psychotherapy is improved self-regulation. In the case of normative theories of mental health, successful psychological treatment just is whatever causes the patient to regulate her responses to fit within the established norms of 'healthy' functioning. In the case of naturalist function-based theories of mental health, whatever the mental dysfunction is that is hypothesized to be responsible for a particular mental disorder, the *proper* function of this hypothesized mechanism involves the ability$_2$ to self-regulate. This is not to say that function-based theories are committed to the claim that self-regulation is the only function of the mind or that self-regulation is the ultimate function of all mental mechanisms. However, if, after successful therapy, the proper functioning of some hypothesized mental mechanism involves persons being unable$_2$ to self-regulate, then we should take this as evidence that we are mistaken about our standard of mental health.

There is nothing that should be recognizable as a *mental* disorder (as opposed to a neurological disorder) that does not involve a problem of self-regulation.[16] For example, if a naturalist-inclined therapist claims that a patient seeking treatment for major depression is 'healed' (i.e., her hypothesized dysfunctional mechanism(s) have returned to normal functioning), yet reports that the patient is still unable$_2$ to regulate her negative emotions and cognitions, we should conclude that the therapist is confused about what depression is. Similarly, obsessive compulsive disorder (OCD) involves the experience of recurring intrusive and unwanted thoughts, urges, or impulses, as well as compulsive repetitive behaviors or mental acts to suppress or ignore these obsessions; any psychological intervention that successfully treats OCD necessarily requires that patients become able$_2$ to regulate their responses to their obsessions and compulsions. And we see the same patterns with other paradigmatic disorders. Different mental disorders involve different regulatory problems: anxiety disorders are marked by excessive anxiety and worry, and difficulty in controlling these worries; schizophrenia is marked

[15] Of course, a theory of mental health and disorder may end up revising our pretheoretical assumptions about the observed 'symptoms' used to construct the theory.

[16] Possible exceptions to this claim are some of the Cluster B personality disorders. The skill view entails that at least some personality disorders are not mental disorders *if* it is the case that they do not involve inabilities$_2$ to skillfully self-regulate. And this is just what we should expect. If a putative nosological entity such as narcissistic personality disorder does not involve any inability$_2$, it seems clear that the behavior being pathologized better reflects disvalued behavior and character, not poor health.

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by delusional beliefs or hallucinations as well as disorganized speech and behavior; bi-polar disorders may involve both serious depressive symptoms and manic behaviors and patterns of thought (American Psychiatric Association, 2013). It is an open empirical question how best to treat these disorders, but the end-goal of psychotherapeutic treatment is the same: no successful treatment leaves patients unable$_2$ to regulate their responses to these symptoms.

Theories of psychotherapy differ over the *causes* of the symptoms that are being regulated, and over how to best ameliorate these problems. But, regardless of whether the therapy focuses on identifying and challenging core beliefs, providing insight into subconscious processes, extinguishing learned behavioral responses, or ameliorating any other hypothesized cause of psychopathology, successful psychotherapeutic interventions involve the patient (re)gaining the skill to self-regulate. If successful treatment does not involve the patient (re)gaining some ability$_2$ to intelligently control how she responds to thoughts, emotions, and events, then it is unclear what is supposed to be 'successful' about the therapy. For example, no effective psychotherapy for anxiety (measured by the patient no longer fitting the diagnostic criteria for a disorder) leaves the patient unable$_2$ to regulate how she responds to anxious feelings, thoughts, or (formerly) anxiety-producing life events. And no effective therapy for schizophrenia leaves a patient without the ability$_2$ to regulate her mental phenomena. This is not to say that effective therapy needs to completely excise all symptoms from patients' mental lives; individuals can experience anxious thoughts, intrusive thoughts, compulsions, and hallucinations without fitting the diagnostic criteria of any mental disorder. This is also not to say that improved self-regulation is the *only* goal of all psychotherapies, or that it is even necessarily an explicit goal. The point here is that if psychotherapy is effective, it is effective insofar as it enables improved self-regulation.

If there is no problem of self-regulation, then there should be no problem of mental health. However, some state's not being a *mental* disorder does not mean that it is not a disorder. The focus on skilled self-regulation helps explain the common distinction between mental disorders and neurological disorders. Neurological disorders, such as amnesia disorders, epilepsy, learning disorders, dementia, and Alzheimer's disease, may result in failures of self-regulation, but they are not best treated as regulatory problems. Treatment for neurological disorders such as Alzheimer's disease may include skill training (e.g., learning to cope with the fear and frustration sometimes associated with memory loss), but even if a patient were to (somehow) be able$_2$ to skillfully self-regulate, this would not make it the case that she no longer has a disorder (though it may be less subjectively distressing). In contrast, if an individual seeking treatment for a mental disorder such as depression or anxiety no longer has a problem skillfully self-regulating, then there should no longer be any disorder. What makes a mental disorder *mental*, rather than somatic, is that mental disorders are best explained and treated as problems of skilled self-regulation while somatic disorders are not.[17]

[17] Graham (2013) makes a similar point.

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Both normative and function-based naturalist theories should agree with this; they just disagree about whether individuals with mental disorders are regulating their mental lives to an objective standard of health, and what, if anything we need to posit in *addition* to self-regulation to explain mental health. For normative views, the additional explanatory piece is a value-judgment. According to these views, while self-regulation plays a role in mental *healing*, whether the healing is successful, and, more generally, whether an individual is judged to be mentally *healthy*, depends on a value judgment of some kind. In contrast, function-based naturalist theories posit that we need the extra concepts of normal function and dysfunction in order to establish a value-independent basis for the distinction between health and disorder (and between healthy and disordered self-regulation). The problem, as we've seen, is that the use of function to draw this boundary leads to serious epistemic and conceptual problems. The concept of skill can do better.

3.4 Skill, mental disorder, and the boundary problem

There are two related, but distinct, concerns about boundaries that theories of mental disorder must address: the first is a metaphysical issue ('*what* is the difference between mental disorder and health'), the second epistemic ('how might we *know* the difference'). The epistemic boundary problem will be addressed in section 3.5. This section is focused on the metaphysical question.

Claim (2) states that mental disorder is unskilled self-regulation. According to the skill view, the boundary between mental health and mental disorder is a question of ability$_2$ to intelligently self-regulate. This does not entail that any regulatory failure is necessarily a sign of mental disorder. Healthy individuals can and do lose control of their thoughts and emotions, and act in ways contrary to their explicit intentions. This is normal and often benign. The difference between normal regulatory lapses and breakdowns of skilled self-regulation (and, thus, the difference between mental health and disorder), is that disorders involve an *inability*$_2$ to self-regulate, not just the poor exercise of regulatory skill. Just as a skilled athlete does not become unskilled when she misstrikes a ball or makes a tactical mistake, mentally healthy individuals do not become disordered merely by engaging in dysregulated behavior. The boundary between mental health and disorder is a question of what individuals are able$_2$ to do, not just what they do.

This solution to the boundary problem provides a principled, value-independent distinction between mental disorders and merely socially disvalued behaviors. Mental health requires being *able*$_2$ to regulate one's responses to emotions and cognitions, but not necessarily that one regulates the content of these mental states to any particular end. The difference between paradigmatic mental disorders (such as GAD or OCD) and instances of normal human variation (such as fringe religious or political beliefs) is that the latter involve the *ability*$_2$ to skillfully self-regulate, while the former do not. This is not to say that individuals with a mental disorder do not have the capacity to self-regulate (presumably they do), but only that at the time in question they do not have the ability$_2$ to

intelligently do so.[18] A mentally healthy political radical who suffers as a result of her beliefs could (in the sense of having the ability$_2$) choose not to focus her mental life exclusively on her political views, while an individual suffering from GAD is not, at that time, able$_2$ to skillfully regulate her anxious emotions and cognitions. Similarly, the skill view entails that while some sexual thoughts or behaviors may be symptoms of a mental disorder (e.g., unwanted and intrusive obsessive sexual thoughts and images), there is nothing necessarily disordered about any particular norm-transgressing sexual behavior or thought. Mental disorders (such as OCD) can be differentiated from non-disordered states (such as homosexuality) because the former, but not the latter, necessarily involve the inability$_2$ to successfully regulate cognitive and emotional patterns. The content or object of one's sexual desires, as opposed to the ability$_2$ to intelligently regulate one's responses to these sexual thoughts or desires, have no necessary relation to mental health. Being attracted to some object *O*, is not necessarily a problem; being unable$_2$ to regulate one's responses to one's *O*-directed obsessions and compulsions is.[19]

It is *possible* that individuals with norm-transgressing sexual orientations or preferences may experience distress at their sexual thoughts and desires (e.g., because they run counter to social norms) based on their inability$_2$ to alter or control the *content* of these thoughts and desires. This felt need to control the object of one's sexual desires and thoughts may lead to mental health problems, but this does not entail that there is anything pathological about the *content* of these thoughts or the *objects* of these desires. These problems, if disordered, would be mood disorders (likely influenced by cultural norms).

The focus on skill, rather than function, also explains the difference between disorder and normal human difference. People differ greatly in the content of their mental states. There is nothing necessarily disordered about atypical or norm-transgressing beliefs or emotional reactions, and a theory of mental health should reflect this. This normal human variation reflects a disorder only when persons are no longer able$_2$ to regulate these mental states. For instance, both a philosopher and an individual suffering from psychotic episodes may claim that the moon does not exist.[20] Both persons may present arguments in defense of this claim, and both may also become emotionally agitated when others disagree with them. The difference between a philosopher denying the reality of the moon (and, say, all other non-living composite objects) and a person suffering from delusional beliefs is that, presumably, the philosopher has the ability$_2$ to challenge and regulate her thoughts and beliefs about the moon while the person suffering from delusions cannot. Similarly, most people report experiencing intrusive thoughts (e.g., about unwanted sex acts, violence, contamination, etc.), while only a small minority meet the diag-

[18] 'Capacity', here, refers to the neurocognitive resources necessary to acquire the relevant ability$_1$.

[19] This argument extends to desires and behaviors currently falling under the category of 'Paraphilic Disorders' in the DSM-5.

[20] The example is adapted from Van Inwagen (1990).

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nostic criteria for obsession-related disorders (Rachman & Silva, 1978; Radomsky, 2014). The difference between normal (if still distressing) intrusive thoughts, and disorders (such as OCD), is demarcated by individuals' ability$_2$ to intelligently regulate their cognitive and emotional responses to them.[21] The difference between mental health and disorder, in general, is drawn by individuals' ability$_2$ to regulate their mental lives, not by the content or objects of their cognitions and emotions.

It is important to note what the skill view is *not* claiming. The skill view is not claiming that mental content plays no role in the etiology or experience of mental disorders- this is clearly not the case. For example, negatively valenced thoughts and emotions are constitutive of depression; a necessary condition of what it is to be depressed is the presence of depressed mood or diminished pleasure. But the presence and prevalence of negatively valenced mental content is not sufficient for mental disorder. Nihilists and existential philosophers may regularly think about the meaninglessness of life, and may even feel intense and persistent angst or sadness in response to these thoughts, but they needn't be suffering from clinical depression (or any other mental disorder). A predominance of negatively valenced thoughts and emotions may play a causal role in the development of depression, but this need not be the case. One needn't be disordered to believe that life is meaningless and painful, to devote much of one's mental life to these beliefs, and to even be profoundly saddened by this. What makes a state marked by negatively valenced mental content a *disorder* is the failure of skilled self-regulation of this content, not merely the presence of any specific thoughts or emotions. The difference between normal (even if intense) sadness, dysphoria, or hopelessness, on the one hand, and depression on the other, is that depression (and mental disorders in general) involve an inability$_2$ to skillfully regulate how one responds to mental content. Mental content, then, plays a role in mental health insofar as responses to content are often what is being regulated, but the presence or absence of any particular mental content does not explain why certain states are disordered and others not. If there is a mental health problem, it is because of a failure of skilled self-regulation, not because of content being regulated.

The skill view is also not claiming that *any* problem of self-regulation is a problem of mental health. There are numerous instances of poor self-regulation that are clearly not disorders. These problems can range from the seemingly trivial (e.g., one can have difficulty resisting a bowl of sweets), to the potentially more serious (e.g., sticking to a diet, or keeping one's temper while watching a sporting event). The skill view predicts that these cases are, or at least can be, normal problems of living. Normal problems of living may be harmful and distressing, but they become mental disorders only if they involve unskilled self-regulation (which requires a genuine inability$_2$ to intelligently modify, override, or change one's responses). Having difficulty regulating one's diet is not a mental disorder, being

[21] The skill view provides a similar explanation for the symptoms of schizophrenia. Both the positive and negative symptoms associated with schizophrenia can be found in the absence of any mental disorder (Van Os & Reininghaus, 2016). These 'symptoms' reflect a disorder only insofar as they involve an *inability$_2$* to skillfully regulate how a person responds to them.

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unable$_2$ to skillfully regulate one's food intake is. And this is just what we should expect: mental disorders (such as eating disorders) involve genuine inabilites$_2$ to skillfully self-regulate; normal problems of living (such as having a problem limiting carbohydrates in one's diet) do not.

The skill view does not claim that a lack of the *capacity* (as opposed to ability$_2$) to skillfully self-regulate entails that an individual has a mental disorder. Infants and small children may be unable$_2$ to skillfully self-regulate, yet they are clearly not mentally disordered. The skill view argues that mental disorders are failures to skillfully self-regulate; this assumes that one has the capacity to accomplish this act. In the case of adult mental disorders, the disorders usually involve an inability$_2$, rather than an inability$_1$, to self-regulate (e.g., an adult experiencing clinical depression is likely to be able$_1$ to self-regulate, but may be temporarily unable$_2$ to exercise this skill). In contrast, infants and small children are poor self-regulators not because of a breakdown or failure of ability $_{(1 \text{ and } 2)}$, but because of the lack of the development of the psychological tools necessary to skillfully self-regulate. Small children do not have a problem of ability, but a (normal) lack of capacity.

The skill view is also not claiming that the act of self-regulation, by itself, explains mental health. The act of self-regulation may be necessary for mental health, but it is clearly not sufficient; mental health, according to the view defended here, is *skilled* self-regulation. For example, an individual under the influence of intoxicants or psychotropic drugs may be willing to engage in harmful activities and regulate their responses towards this end. Similarly, a person experiencing a manic episode (which is often marked by grandiosity, flight of ideas, and increased goal-directed behavior) may successfully regulate her responses towards some mania-inspired standard. Neither case of successful self-regulation is normally considered to be part of healthy mental states. The difference between mere successful self-regulation to a potentially harmful standard, on one hand, and mental health, on the other, is that mental health requires the ability$_2$ to intelligently and flexibly modify one's responses. This skill is often masked or absent while individuals are experiencing delusions, manic states, or are under the influence of psychotropic drugs.

The skill view also does not entail the (false) claim that mental disorders require a global inability$_2$ to self-regulate. Individuals suffering from addictions, for example, may be able$_2$ to regulate their responses to their addiction-specific urges and desires in some circumstances (e.g., while in the presence of a police officer). The skill view claims that mental disorders require an inability$_2$ to *skillfully* self-regulate (which is consistent with individuals being able$_2$ to merely successfully regulate their responses in some situations).

The skill view is also not claiming that mental health requires the ability$_2$ to skillfully regulate one's responses to all possible stimuli. For example, consider someone who lives an utterly untroubled mental life, but who might contingently be unable to skillfully self-regulate their responses to some psychiatric symptoms (say, auditory hallucinations) in other circumstances which, fortunately, do not ob-

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tain. Intuitively, although this person may lack the skill to regulate her responses to certain psychiatric symptoms (if they were to manifest), this is a person in good mental health. And this is what the skill view predicts. The skill view argues that mental health is the skilled action of regulating *one's* responses to *one's* mental phenomena (not to all possible mental phenomena that a person may experience). In the hypothetical case noted above, the individual is mentally healthy as long as she is able to regulate her responses to *her* mental phenomena (which, in this case, does not involve any psychiatric symptoms). This person may certainly *develop* a mental disorder if she were to develop psychiatric symptoms that she was unable to intelligently self-regulate, but she is not mentally ill just because she lacks the skill to regulate her response to symptoms that she does not have.

The skill view also does not entail the (false) claim that all instances of mental healing necessitate the development of *new* skills. Mental healing *may* involve the development of new self-regulatory metacognitive skills, but it may also involve the unmasking of previously developed skills. Mental health requires the exercise of self-regulatory metacognitive skill, and this can be accomplished in many ways (e.g., by acquiring new skills, strengthening old skills to adapt to new conditions, or by removing environmental factors that mask or overwhelm one's current ability_1 to intelligently self-regulate).

Finally, as noted in Section 2, the skill view adopts a restricted definition of self-regulation that focuses on whether individuals are able_2 to intelligently alter, modify, or control their responses to their mental phenomena, regardless of the standard that they are attempting to regulate to. This is not to claim that the standard is irrelevant to health; individuals' goals or standards are often part of the problem that therapy is attempting to ameliorate (e.g., overly high or 'perfectionist' standards). In the case of perfectionist or unrealistic goals, therapy may attempt to modify a patient's high standards, but the high standards are maladaptive only if the patient is genuinely unable_2 to intelligently alter or control how she responds to them. Impossibly high standards needn't be maladaptive, and may often serve as useful motivators. The skill view argues that mental health is determined by one's $\textit{ability}_2$ to intelligently modify, alter, control their responses towards the achievement of some end; it does not matter (at least in the context of mental health) how well one does this or how achievable the goal is.

3.4.1 Skill and function

The skill view offers a naturalist definition of mental disorders that is conceptually superior to traditional function-based views. The skill view, in contrast to function-based views, captures what is disordered about mental disorders (i.e., a failure of skilled self-regulation) without revising our conception of paradigmatic disorders and without pathologizing normal human difference. Unlike dysfunction views, the skill view predicts that paradigmatic mental disorders such as depression, anxiety, and schizophrenia are clear instances of disorder insofar as they

involve failures of skilled self-regulation. And, unlike dysfunction views, the skill view predicts that mental states that merely involve norm-transgressing mental content and behavior (or even dysfunctional mental mechanisms), but do not involve problems of skilled self-regulation (such as homosexuality, asexuality, and norm-transgressing gender-identification), are clearly not mental disorders. Mental disorders are best conceived of as problems of skilled mental regulation, not mental content or the proper functioning of mental mechanisms.

The skill view of health, in contrast to function-based views, is also consistent with divergent theories of psychopathology and psychological healing. The causes of breakdowns in skilled self-regulation are likely various, and may include physiochemical, genetic, cognitive, or environmental factors (and likely some combination of multiple variables). A significant advantage of the skill view over function-based views is that the identification of mental disorders does not depend upon the truth of any particular theory of psychopathology and psychological functioning. According to function-based views, accuracy about the etiology of hypothesized disorders is crucial, given that whether or not some way of being (such as anxiety or homosexuality) counts as a disorder necessarily depends on whether it is the result of a mental dysfunction. The skill view of health, on the other hand, is compatible with the etiology of mental disorders being an open empirical and conceptual question. Mental disorders are failures or breakdowns of skillful self-regulation, *whatever the cause.* Regardless of whether the etiology of a disorder is best described by a cognitive-behavioral theory, psychodynamic theory, or any other theory of psychopathology, if some state is a disorder, it is marked by an inability$_2$ to skillfully self-regulate.

3.5 The epistemic boundary problem

The skill view draws the metaphysical boundary between health and disorder at individuals' ability$_2$ to intelligently self-regulate. There remains the question of how we might know when this is the case. There are two types of epistemic challenges in identifying mental disorders: one is nosological, the other diagnostic. The nosological question is concerned with identifying what types of mental phenomena are and are not mental disorders (i.e., is the mental state normally associated with depression a disorder or a mere problem of living?). The diagnostic question is concerned with how clinicians might identify disorders, given the answers to the nosological question (i.e., how might we know if an individual meets the criteria for any given mental state that we postulate to be disordered?). This section argues that there is a degree of vagueness in the answer to both questions, but, importantly, the epistemic uncertainty facing the skill view is more benign than the vagueness facing function-based views.

The skill view identifies mental disorders by identifying inabilities$_2$ to intelligently self-regulate. This requires identifying when individuals cannot flexibly alter or control how they respond to their thoughts, emotions, and behaviors. So,

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identifying specific disorders (such as depression, anxiety, and OCD) is a matter of identifying inabilities to skillfully self-regulate (e.g., to regulate responses to depressive thoughts and emotions, anxious feelings and worry, or obsessions and compulsions). Psychometric and diagnostic tools like the DSM-5 and ICD-10 are heuristics that should be seen as doing just this. While no one should think that these diagnostic tools are carving nature at its joints, they do a good, but imperfect job of identifying when individuals are unable$_2$ to intelligently self-regulate and are in need of help. Diagnostic tools are, of course, imprecise (e.g., there is no metaphysical significance to the DSM-5's requirement of a minimum of two-weeks of symptom expression for the diagnosis of major depressive disorder, as opposed to three weeks or ten days). And diagnostic tools may be based on mistaken nosological assumptions (e.g., homosexuality was considered a mental disorder in the DSM-II and was not fully removed until 1973). However, while the diagnostic tools' lack of precision clearly has practical implications (insofar as diagnoses often entail improved access to resources and aid), this epistemic problem does not reflect a metaphysical shortcoming of the skill view (i.e., the skill view provides us with a framework to differentiate between accurate and mistaken nosological claims: we know that if someone is genuinely unable$_2$ to skillfully self-regulate, then they are experiencing a mental disorder).[22] The issue here is one of psychometrics, not metaphysics.

The skill view also faces no unique diagnostic challenges. While the skill view and function-based views may differ over their nosological commitments, both views have to rely on the same diagnostic and psychometric tools (such as the DSM-5 and ICD-10, and the Beck Depression Inventory and the Hospital Anxiety and Depression Scale, respectively) in order to differentiate between health and disorder for any hypothesized nosological entity. For instance, even if one were to adopt a function-based conception of mental health, identifying the precise border between any particular individual's *poor* functioning (say, normal, but intense, anxiety) and *dys*-functioning (say, GAD) still comes down to the arbitrary drawing of lines. Similarly, whether an individual is unable$_2$ to intelligently self-regulate (as opposed to just being a poorly skilled self-regulator) is not always clear. But in both cases, this is an issue of psychometrics, not metaphysics. Providing a specific answer to the diagnostic question is going to be a problem for *any* naturalist view, and the existence of fuzzy boundaries between health and disorder for any particular nosological entity is problematic only if we take diagnosis to accurately reflect metaphysical distinctions rather than serving as imperfect heuristics to identify breakdowns of skilled action.

Both dysfunction views and the skill view accept that diagnostic boundaries are fuzzy. This is a serious *practical* problem, but not a metaphysical one. What is crucial for a naturalist theory of mental disorder is that it provides a plausible value-neutral metaphysical grounding from which we can base the epistemic dif-

[22] In contrast, the imprecision of diagnostic tools is a serious problem for function-based views given the etiological commitments noted in section 3.4.1.

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ferentiation of genuine disorders from mere problems of living and value-based 'disorders'. The skill view does this.

4 The skill view and dysfunction

The previous section has shown that the skill view offers us a more plausible answer to the boundary problems than dysfunction-based theories. This section addresses some further points of difference.

A significant difference between the skill view and function-based theories is that the skill view is a theory of *mental* health, not health, full stop. Traditional function-based views adopt the same conception of health for both somatic and mental health. This uniformity may be considered an advantage in their favor. However, the cost of this uniformity in our conception of somatic and mental disorders is a theory of disorder that is both potentially massively revisionary and epistemically weak. This is a high price. While a thorough defense of this distinction is beyond the scope of this paper, it is important to note that the focus on skill, rather than function, closely aligns with how we normally conceive of mental health and healing.[23] Mental health is best conceived of as a quality of *persons*, not of impersonal mechanisms. Dysfunction views assume that the same standard of health can be used for *any* living thing (be it a plant, a bacterium, or a mind). In contrast, the skill view posits different standards of health for minds and bodies. It is far from clear why we would think otherwise. Why think that the questions concerning the health of a mind and the health of a plant or a bone are after the same information? Two concerns may be that adopting different standards of health assumes some sort of substance dualism about minds and bodies and an anti-scientific conception of mental disorders. But neither worry is legitimate. We needn't claim that minds are non-material to also posit that their health is best explained by skill rather than function. Minds are more complex than bones and plants, and it is not surprising that their health is best judged by different standards.

A second significant difference is that many advocates of function-based theories take the concept of normal function to be necessarily connected to our understanding of health. The two most influential naturalist theories of health, Boorse's (1976) 'pure' naturalist theory, and Wakefield's (1992) 'hybrid' view, both appear to share this view. For example, Boorse states that:

> There is clearly some plausibility in the claim that the history of medical theory is nothing but a record of progressive investigation of normal functioning (1977, p. 560).

[23] See: Leder (2019); Zawidzki (2019).

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And Wakefield:

> [It is a] virtual universal tendency to fall back on dysfunction to explain disorder (1992, p. 381).

Boorse and Wakefield may both be correct in claiming that health and disorder (or at least naturalist views of health and disorder) are normally conceptualized in functional terms. But, given the conceptual and epistemic problems facing function-based views, we have little reason to continue to do so. The intuitive strength of the presumed connection between normal function and health, if felt at all, should be dependent upon whether or not function-based conceptions of mental disorder can offer us explanatorily successful theories of health and disorder. The concept of natural function hasn't been able to do this. Skill can.

5 Broader advantages of the skill view

The previous sections have articulated a precise conception of mental health in terms of metacognitive self-regulatory skill and have shown its superiority to function-based conceptions, relative to a number of core theoretical and practical issues. In this section, we turn to some broader considerations in support of conceptualizing mental health as a skill. In particular, we argue that if mental health consists of metacognitive skills, this (1) shows a way past the historically recurring trilemma of psychiatric reductionism, eliminativism, and dualism; (2) defuses motivations for anti-psychiatry by accommodating cultural variance in mental illness within a value-neutral framework and providing an objective foundation for the scientific study of mental health and healing, and (3) suggests a novel and promising way of striking the delicate balance between stigma reduction and promoting individual agency in mental health.

5.1 Avoiding the reductionism-eliminativism-dualism trilemma

Much of the history of psychiatry can be characterized, with little exaggeration, in terms of a periodic vacillation between three unstable ontological frameworks: reductionism, eliminativism, and dualism. According to reductionists, psychiatric disorders are nothing over and above (neuro-)physiological dysfunctions. According to eliminativists, psychiatric disorders do not really exist; only (neuro-)physiological dysfunctions exist. According to dualists, psychiatric disorders are afflictions of a domain which is, in some sense, autonomous from (neuro-)physiology. Each of these frameworks has ultimately proven unstable, for different reasons. Reductionism assumes that psychiatric disorders can be mapped directly onto (neuro-)physiological dysfunctions, but, as noted above, this has repeatedly been shown to be untenable. Eliminativism makes psychiatry (as commonly practiced) impossible, and jeopardizes the very notion of mental

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health. And dualism makes mysterious the patent dependence of mental health and disorder on physiological and other physical factors. It is plausible that one reason these three unstable, alternative frameworks have proven perennially seductive consists in the underlying assumption that mental disorder must consist in some kind of dysfunction. If it is not a (neuro-)physiological dysfunction, then it must either not exist, or consist in the dysfunction of some non-physical capacity. However, if mental health is conceptualized as a skill, then this seductive trilemma can be avoided.

This is best appreciated in terms of an analogy to a typical embodied skill. Consider tennis again. Nobody is at all tempted by either reductionism, eliminativism, or dualism about skill at tennis. Although (neuro-)physiological functionality, and other physical factors are required to successfully acquire and execute skill at tennis, there is no sense in which skill at tennis is the same thing as (neuro-)physiological functionality; this is why lack of skill at tennis is clearly not any kind of (neuro-)physiological dysfunction. However, this in no way supports eliminativism about skill at tennis; it is clearly a real phenomenon. Nor does the fact that skill at tennis cannot be identified with (neuro-)physiological functionality in any way make dualism about skill at tennis at all tempting.

Skill at tennis just seems to belong to the wrong logical category to even raise the question of whether or not it consists in (neuro-)physiological functionality. The question of whether or not, or to what degree, someone is skilled at tennis just seems entirely orthogonal to questions of (neuro-)physiological functionality. The criteria by which and reasons why we make judgments about the former have nothing to do with the criteria by which and reasons why we make judgments about the latter. If we conceive of mental health in terms of self-regulatory metacognitive skills, rather than in terms of biologically normal functionality, then the fruitless vacillation among the horns of psychiatry's historical, ontological trilemma can be avoided.

In many respects, the idea here resembles Ryle's more general perspective on 'the concept of mind' (1949). Ryle sought to avoid the traditional dilemma between dualism and reductionism (while resisting eliminativism), by arguing that folk psychological concepts are used to track *abilities, skills, and dispositions of persons*, rather than mechanical facts about our (neuro-)physiology, or "para-mechanical" facts about a "spectral" machine somehow lodged within it. Similarly, we claim that the language of mental health and disorder is better understood as tracking metacognitive abilities, skills, and dispositions, rather than facts about (dys-)functioning (neuro-)physiological mechanisms, and that this reconceptualization can help us avoid the persistent ontological trilemma. On our view, like any other skill, self-regulatory, metacognitive skills are valued in specific cultural contexts, can be acquired to greater or lesser degrees by persons inhabiting those contexts, and depend on (neuro-)physiological functionality and other physical facts for their successful acquisition and exercise. None of this requires either reductionism, eliminativism, or dualism about them, any more than about skill at tennis.

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5.2 Respecting cultural variance while avoiding anti-psychiatry

Mental illnesses may manifest different symptomologies in different cultures and across time (Radden, 2003). If we think of mental illnesses as dysfunctions of biological mechanisms, then this kind of cultural variance is hard to explain. The functionalist view is largely motivated by the desire to assimilate psychiatry to the rest of medicine (Wakefield, 1992). But this kind of cultural variance in symptomology seems far less pronounced in the case of somatic illness: COVID-19, cancer, heart disease, etc., all display remarkably homogeneous manifestations across cultures. If the functionalist view is the only possible foundation for scientific psychiatry, cultural variance in mental illness can naturally motivate skeptical and anti-psychiatry views.

In contrast, if we think of mental illness as a deficit in self-regulatory metacognitive skill, then cultural variance can be accommodated without embracing anti-psychiatry or sacrificing the objectivity of mental illness. Although cultures can differ in the sorts of goals relative to which their members want to self-regulate, it remains an objective fact whether or not they are able$_2$, skillfully, to do this. Perhaps the task of managing grief differs across cultures. In one culture, it may require a Stoic return to normal life within a few weeks, while in another, more expressive culture, it might require public expressions of grief over the course of months. Such differences might yield different judgments of mental illness with respect to individuals incapable of meeting such goals. An individual may be judged mentally ill relative to a Stoic culture, even if they are fully within the norm relative to a more expressive culture, and vice versa. However, on the skill view of mental health, there remains an objective fact of the matter as to whether or not they are mentally ill: if they cannot skillfully self-regulate relative to one of their (sometimes culturally determined) goals, e.g., appropriate grieving, then they count as objectively mentally ill. Thus, the skill view predicts that cultural norms may influence the standard one attempts to regulate their responses to, but they do not influence whether any way of being should be considered disordered.

Once again, a comparison to embodied skills is pertinent here. Consider speech therapy. This clearly involves a degree of cultural relativity, since different languages place different phonetic demands on their speakers. Hence, someone may count as speech disabled relative to one language and not relative to another. Nevertheless, there are objective facts about whether or not someone is speech disabled relative to some language, about the relevant (neuro-)physiological capacities, and about the sorts of behavioral interventions that enable them to overcome their disability. Speech therapy is an entirely objective enterprise, based on investigation of such facts and the implementation of relevant interventions. Just as such facts and interventions may partially but not wholly overlap across languages, our suggestion here is that facts and interventions relevant to psychiatric care may partially but not wholly overlap across cultures.

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The skill view offers a robust antidote to anti-psychiatry; self-regulatory metacognitive skills, like embodied skills, involve objective, (neuro-)physiological capacities that psychiatrists can study. This perspective suggests the following taxonomy of objective, psychiatric sciences. Neuropsychiatry can be seen as the study of the neural mechanisms underlying self-regulatory, metacognitive skills. Clinical psychiatry can be seen as the study of the sorts of interventions required to develop or unmask such skills (including therapies involving mindfulness and other forms of metacognitive practice). And applied clinical psychiatry can involve the implementation of such therapies and regimes of practice. The latter might be analogized to such well-established health professions as occupational therapy, which focus on (re-)training of patients wanting to re-enter the workforce after debilitating traumas.

5.3 Striking a delicate balance: Agency without stigma

Perhaps the greatest advantage of the skill view is that it suggests a promising understanding of agency with regard to mental illness which avoids the kind of stigma that typically accompanies failures of rational agency, as traditionally conceived. One often touted, practical advantage of function-based views concerns stigma reduction. If mental illness is no different from somatic illness (i.e., resulting from a biological dysfunction), then, so the argument goes, the mentally ill are no more to blame for their afflictions than those suffering from somatic illnesses. A person suffering from bipolar disorder, for example, should be subject to no more stigma than a person who has caught COVID-19: these are caused by biological dysfunctions for which they are not responsible; they deserve medical care, not blame or stigmatization. Thus, on function-based views, stigma reduction is bought at the price of the near-elimination of agency: like patients with somatic illnesses, the most patients with mental illnesses can do is consult medical experts, and follow their orders and prescriptions. And for this reason, they should not be blamed or stigmatized. In contrast, the skill view offers a more promising means of stigma reduction, which does not depend on such an extreme diminution of agency in the mentally ill.

One traditional reason individuals with mental illness have suffered from stigma has to do with a particular conception of rational agency. The idea is that when a rational agent knows the rational course of action, they are, in virtue of this knowledge alone, appropriately motivated to engage in it. According to the most stringent, traditional versions of this principle, any individual who fails to match this pattern fails to qualify as a rational agent, and hence, does not deserve the regard to which only rational agents are entitled.[24] But such impairments are typical of those experiencing mental disorders: in most mental disorders, individuals know that avoiding the patterns of behavior to which they are prone

[24]This understanding of practical rationality, and its relationship to the central category of moral status, i.e., personhood, has dominated the western philosophical canon, at least since Kant.

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is the rational course of action, yet they are unable$_2$ or inappropriately motivated to avoid them. Viewing mental illness as a dysfunction, rather than such a lapse in rationality, can offer some respite from stigmas that attend the latter. However, these are not the only sorts of stigma that potentially accompany mental illness; biological dysfunctions, like somatic illnesses, carry their own forms of stigma.

The evidence for the association between acceptance of dysfunction views and stigma reduction is mixed. While the acceptance of dysfunction views is associated with a reduction of perceived blame and responsibility of people with mental disorders (Phelan, 2002), it is also associated with an increase in essentialist conceptions of illness (i.e., beliefs that illness is caused by biological processes over which individuals have little control), increased social rejection (e.g., beliefs about the dangerousness and 'otherness' of the mentally ill) (Schomerus, 2012), and prognostic pessimism about recovery (Deacon & Baird, 2009). So, while the 'dysfunction' narrative may reduce blame, it may also promote social rejection, hinder recovery, and diminish patients' sense of agency. Hence, conceiving of mental illnesses as dysfunctions, while protecting against some forms of stigma, may foster others. In contrast, the skill view suggests a conception of agency different from the traditional understanding of rational agency, which has the potential to reduce the kind of stigma that attends failures of the latter, to avoid the stigma that attends dysfunction, and to promote a kind of agency among individuals with mental illness that is necessary for recovery.

The skill view avoids two extreme conceptions of metacognitive agency: (1) taking metacognitive agency entirely for granted, as on some traditional views of rational agency, and (2) diminishing metacognitive agency, as on functionalist conceptions of mental health and illness. On the traditional view, to be practically rational just is to exercise metacognitive agency: one is rational in virtue of willing appropriate means to one's goals; if one cannot do that, one just is not rational. On the functionalist view, there is limited metacognitive agency: choosing appropriate means to one's goals is a matter of normal biological functioning, over which one has minimal control. The skill view provides a third alternative, inspired by notions of agency evident in embodied skill development, a notion of agency that neither ignores nor takes for granted metacognitive agency: on the skill view, metacognitive agency is something that persons can develop and maintain through practice, supported by appropriate social and physical scaffolds (e.g., supportive environments, protection against trauma, and undamaged (neuro-)physiological capacities).

Athletes are rightfully praised for developing and exercising their skills; they have a kind of agency. However, this is not a kind of agency that they have automatically, in virtue of being athletes. It is an agency that they have to develop, through an arduous and gradual process. Similarly, we want to suggest, the metacognitive agency required for skilled self-regulation, in terms of which we understand mental health, is something that can be developed only gradually, through diligent practice (though much of this practice occurs during childhood

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development). It is not a form of agency that we can just take for granted in virtue of being rational. Hence, there are steps that individuals experiencing mental disorders can take to improve their lot, just as there are steps that most persons can take to improve athletic skills. They retain agency. However, it is not the kind of agency presumed by traditional views of practical rationality: it is fragile, and contingent on adequate physical and social scaffolding. A failure to demonstrate this kind of agency does not motivate stigma, in the way that a failure to demonstrate the kind of agency traditionally deemed to be necessary for practical rationality can. With the exception of some outlier communities, nobody is stigmatized for not having had the opportunity to develop tennis skills, for example, or for losing the ability$_2$ to play tennis as the result of some trauma. Similarly, we want to suggest, if we think of mental health as a skill that takes practice, together with contingent physical and social scaffolds, to develop and maintain it, there is no reason to stigmatize those who lack this ability or these opportunities. Thus, we have here a way of allowing for agency in individuals with mental disorder (the same kind of agency that persons in athletics have: the ability$_1$ to acquire or regain skills), while avoiding the stigma that accompanies lapses in traditional rationality and avoiding the stigma that accompanies dysfunction.

It might be objected that the adoption of the skill view may increase negative stigma sometimes associated with mental disorders. The concern may be that the conception of mental disorders as failures or breakdowns of skilled action could encourage the idea that mental disorders are the results of personal weakness. If you want to become more skilled at some mode of functioning, the thought might go, you just need to practice and put in the work to develop it. While it is certainly true that avoiding and recovering from mental illness is to some degree a matter of effort (this is something that most theories of psychological healing accept), conceiving of mental health as a skill does not entail that mental health is merely a question of willpower or effort.

There are constraints to the development of *any* skill that have nothing to do with strength of character or volition. Individuals differ in their potential to develop specific skills due to biological, cognitive, and environmental differences. The skill of mental health, like skill in sports and intellectual activities, depends in large part on one's physical and cognitive capacities. While it is likely that most individuals can improve their ability to perform skilled actions through practice and study, many factors constrain one's development of skills; practice and diligence cannot overcome basic anatomical or cognitive constraints such as visual impairments or neurological deficits. The causes of variance in skill are likely very complex (including, but in no way limited to, a person's prenatal environment, genetics, upbringing, and socio-economic standing), but clearly, they are not just a matter of will-power. The skill of mental health, like embodied or intellectual skills, is something that must be developed and maintained, and is significantly constrained or enabled by physiological and environmental factors.

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6 Conclusion

We have shown that a focus on skill, rather than function, provides us with a more explanatorily robust and pragmatically useful theory of mental health. On a theoretical level, this conception of mental illness allows for more intuitive and tenable assignment of extensions to our mental illness categories. On the pragmatic level, the focus on metacognitive skill rather than function enables a conception of mental disorder that is consistent with the scientific study of psychopathology while also promoting human agency. Mental health, according to the skill view developed here, is something that individuals *do*.

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