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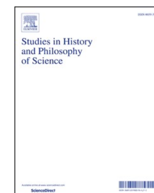

Mental health promotion and the positive concept of health: Navigating dilemmas

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ABSTRACT

A prevailing view holds that the main goal of mental health promotion is to maintain and improve *positive* mental health, which is not merely defined by the absence of mental disorders, but by the presence of certain abilities. There are, however, challenges associated with this view that this paper aims to identify and explore. We start by highlighting three requirements for an ethically and politically justified mental health promotion scheme: (i) using a positive concept of mental health that (ii) respects the neutrality principle while (iii) not being overly permissive. Then, we argue that the WHO's positive concept of health violates (ii), and continue by exploring three philosophical accounts (i.e., Nordenfelt, 1995, 2017; Graham 2010; Wren-Lewis & Alexandrova, 2021) that could potentially provide a solution. We show that these face a dilemma of their own: they either violate (ii) or (iii), and they can rectify one issue only by violating the other. Considering the problems linked to the positive notion of health, the final section explores the alternate route of rejecting proposition (i) and instead embracing a negative concept of health. We argue that this option does not present a more advantageous solution. We conclude by highlighting the necessity for additional research to tackle the challenges we identified.

In the past few decades, the scope of health promotion has expanded to encompass *mental health promotion*, which involves taking action to address potentially modifiable factors that influence mental health, as defined by the WHO (1998; 2001). At the same time, there has been a significant rise in research and political attention towards mental health promotion (Paldam Folker & Rod, 2016). As evidenced in the WHO's global action plan 2013–2020 (WHO, 2013) and the Perth Charter (2012), there is now consensus that mental health should be integrated into public health initiatives and treated with the same importance as physical health.

Such a growing emphasis on mental health has been driven by two substantial factors. The first is the recognition that mental health is essential for overall physical health and well-being. In recent years, researchers have found a strong link between mental and physical health, even after adjusting for other factors (Ohrnberger, Fichera & Sutton, 2017; Prince et al., 2007). While the exact mechanisms behind this relationship are not fully understood, poor mental health is a risk factor for disease and premature mortality. The second factor is an improved understanding of the impact and scope of mental health issues and the socio-economic benefits of promoting mental health (OOPEC, 2005). Even as physical health status has remained relatively stable, there is a marked increase in the proportion of people reporting poor mental health (Baxter et al., 2014; Jensen et al., 2018). Mental health problems now constitute about a quarter of the total disease burden (Whiteford et al., 2013; WHO, 2008; Juel et al., 2006), and mental health promotion is increasingly recognized as a neglected but highly profitable social investment that could produce noteworthy socio-economic benefits (Knapp et al., 2011, p. 43).

The developments outlined above have propelled investigative efforts within the realm of mental health promotion. Nevertheless, there seems to be a noticeable lack of research focusing on the specific concept of mental health that underpins health promotion initiatives. Many national and supranational entities in mental health promotion work with the WHO's (2001) *positive concept of mental health*, which ties mental health to well-being, operates under a positive psychology framework, and understands mental health not merely as the absence of disorder, but the presence of a certain state of mental well-being and certain mental abilities. Mental health and mental disorder are regarded as two separate dimensions rather than a continuum (Keyes, 2014; Perth Charter, 2012), such that it is possible to have low mental health without

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having a mental disorder and relatively high degree of positive mental health while having a chronic mental disorder (Keyes, 2014). In this perspective, the overall goal of mental health promotion is the maintenance and improvement of positive mental health. In addition, it is commonly assumed that emphasizing the improvement of positive mental health is a more efficient approach than focusing solely on mental disorders. As Corey Keyes (2014, p. 11) succinctly expresses it, "if you want better mental health, you need to focus on positive mental health."

There is a thus growing global emphasis on promoting mental health, which is based on a positive concept of mental health. This paper will argue that there are major challenges associated with adopting a positive concept of mental health, which so far remain unacknowledged. First, in section (1), we highlight three requirements for ethically and politically justified mental health promotion schemes. They require (i) using a positive mental health concept that (ii) respects the principle of neutrality while (iii) not being overly permissive. Then, considering that many organizations involved in mental health promotion utilize the WHO's definition, in section (2) we subject this definition to scrutiny and argue that mental health promotion using the WHO's definition risks violating (ii), as it implies a *normatively controversial* view of a good life. Subsequently, in section (3), we explore three philosophical accounts (i.e., Nordenfelt, 2017; Graham, 2010; Wren-Lewis & Alexandrova, 2021) that could potentially provide a solution. We argue that these face a dilemma of their own: they either violate (ii) or (iii), i.e., they can rectify one issue but only by transgressing against the other. Considering the issues linked to the positive notion of health, the final section (4) explores the alternate route of rejecting requirement (i) and instead embracing a negative definition of health. Nonetheless, we argue that this choice does not present a more advantageous solution. Overall, while the paper makes progress in identifying and outlining the challenges, emphasizes the importance of resolving them, and explores existing accounts that could offer potential solutions, additional research is still needed for their effective resolution.

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1. Three requirements for mental health promotion

Public health measures focus on protecting and promoting the mental health of the population and are typically implemented by the state and its institutions. As such, they require ethical and political justification for several reasons. For example, the fact that these institutions use public funds to promote mental health raises questions about distributive justice with respect to the allocation of costs and benefits among different populations. The scarcity of relevant resources necessitates their distribution in the most efficient manner possible, to prevent wasting time and financial resources. Moreover, it can be problematic if health promotion programs lead to the stigmatization of certain conditions, over-medicalization or under-treatment, interference with autonomy, a threat to social equality, or supporting dominant ways of life as healthy at the expense of marginalized alternatives. We will assume here that because any mental health promotion scheme will be embedded in complex global and national contexts, as well as have decisive impacts on people's well-being, such schemes should aim for political and ethical justification. This section will concentrate on three requirements for this aim. These requirements are understood as necessary conditions, the objective is not to provide a comprehensive list of jointly sufficient conditions.

The first requirement is linked to the fact that mental health promotion utilizes limited public resources, necessitating a focus on cost-efficiency to ensure their fair distribution. This includes ensuring that the resources in question are allocated in a manner that best approximates the desired distribution of health benefits, e.g., as prioritizing the worse off, those with the most serious conditions, or the most socially disadvantaged, or merely maximizing health benefits. In addition, the use of cost-efficiency measures promotes transparency, permitting stakeholders to understand how decisions are made about resource allocation. This contributes to maintaining public trust, which is essential for success, as it likely incites individuals to support and participate in health promotion policies and initiatives.

To ensure the cost-efficiency of mental health promotion, prominent voices within the domain of mental health promotion emphasize the necessity of using a *positive concept of mental health*. This view transitions the emphasis from prior measures, which aimed at simply preventing or addressing mental disorders. Keyes (2014), a proponent of this view, stresses that while a history of mental disorder is a reliable indicator of potential future mental health problems, a lack of mental health in the positive sense serves as an equally strong or perhaps even stronger predictive factor of mental disorder. This is because the absence of positive mental health can contribute to the emergence of somatic and mental disorders over time, perhaps due to chronic stress, lack of coping mechanisms, or a sense of hopelessness or social isolation. Considering such findings, Keyes suggests that cost-efficiency requires a focus on promoting positive mental health. As Keyes (2014, p. 11) puts it, "if you want better mental health, you need to focus on positive mental health." This should not be understood in the sense of targeting positive health instead of negative health; mental health promotion will still require treatment for people with mental disorders. The point is that health promotion should go beyond such treatments, as this will be more cost-effective in the long run. This position is popular in the literature, and for the purposes of this paper, it is accepted as a foundational premise. Together with our previous considerations, this means that justified mental health promotion is intrinsically linked to cost-efficiency, and realizing cost-efficiency mandates the promotion of mental health defined by a positive concept. This leads to the first requirement.

(i) *Positive Health.* An ethically and politically justified scheme of mental health promotion requires targeting mental health in the sense of the positive concept.

This perspective challenges the traditional approach to mental health promotion focusing directly on mental disorders and opens up new possibilities for interventions and policies aimed at fostering resilience and (mental) well-being. This might involve implementing programs to promote coping skills, a sense of social connectedness, positive emotions, a sense of purpose, but also interventions targeting the social determinants of mental health.

The second requirement concerns the impact of health policies and interventions on the lives of individuals. As such measures have the potential to intrude into the lives of citizens, they necessitate a careful balance between achieving public health goals and respecting civil liberty rights, autonomy, and diverse conceptions of the good life. Often tied to the notion of respecting autonomy, an influential tenet in liberal democratic societies is that state policies and interventions should respect the *principle of neutrality*[1]: they should refrain from promoting a particular conception of the good life over others, but focus instead on basic capacities and functioning that individuals need to pursue their own conception of the good, as long as these do not violate the rights and freedoms of others (Mason, 1990). This means that to be ethically and

[1] This can be articulated in various ways, but one rough articulation is as follows: if we accept that (a) respecting persons necessitates respecting each person's autonomy, and that (b) the exercise of autonomous agency may result in the adoption of diverse conceptions of the good life, then it follows that respect for each person's autonomy mandates the state to maintain neutrality among these varying interpretations of the good life.

politically justified, mental health policies and interventions ought to respect the principle of neutrality.

We should add that the principle only asserts that the appropriate interventions and policies are settled without relying on *controversial* claims regarding what is good. A conception of the good might be deemed *descriptively* controversial (i.e., it is subject to actual disagreement) or *normatively controversial* (i.e., there is a rational basis for controversy, such that it would lead to disagreement among reasonable individuals possessing standard cognitive abilities). In this context, we are interested in normative controversiality, and this brings us to the second requirement.

(ii) *Neutrality*. An ethically and politically justified scheme of mental health promotion respects the principle of neutrality in the sense that it does not promote any normatively controversial idea of the good life.

A clarification is in order. Neutrality is often divided into three categories: the neutrality of aim, justification, and effect (see e.g., Arneson, 2014). The first category, *neutrality of aim*, demands that actions or policies pursued by the state should not aim to promote one conception of the good over another. The second category, *neutrality of justification*, demands that policies should be justified without appealing to the purported superiority of one conception over another. The third category, *neutrality of effect*, requires that policies are avoided that bring about that one conception of the good (and their adherents) is privileged over other conceptions. In this context, following Rawls (1988, p. 263), we focus on neutrality with respect to aim and justification, but not to effect.[2]

The third and final requirement is related to the fact that interventions aiming to promote mental health address not just risk factors for mental disorders but also the determinants of well-being. As these interventions using a broad positive concept of health are conceived of as mental *health* interventions, they could inadvertently pave the way for medicalization, i.e., a process where issues previously not seen as medical in nature are progressively defined and treated as health problems that are best managed by health professionals (Parens, 2013; Sholl, 2018). For example, individuals with severe social awkwardness and shyness were not traditionally seen as having a medical condition. However, in recent times, there is an increasing tendency to diagnose such individuals with mental disorders like social phobia or social anxiety disorder (Cunningham, 2002).[3] This leads to the third requirement.

(iii) *Non-permissiveness*. An ethically and politically justified scheme of mental health promotion does not use an overly permissive notion of mental health, as doing so could contribute to overmedicalization.

It is critical to note that while medicalization is a value-neutral term, what renders it problematic is its tendency to facilitate *overmedicalization*, which refers to the inappropriate use of medical resources to address political, social, and personal issues. While there are several concerns that have been voiced about overmedicalization (e.g., Conrad, 2007; Scott, 2006; Varga, 2022), we may here suffice with three that seem particularly relevant for the context of mental health. First, overmedicalization shifts the problem-solving focus to interventions of medical nature, diverting attention away from the political and social structures that create conditions where certain conditions (e.g., severe shyness) becomes increasingly debilitating. This might hinder genuine public discourse that could lead to a reevaluation of prevailing values in contemporary culture, such as the emphasis on extroversion and the ability to perform effortlessly in social interactions. Second, overmedicalization can lead to unnecessary medical treatments and the pathologization of normal variations in behavior and experience. Finally, overmedicalization seems to be causally linked to an increase in health concerns. The surge in conditions and risk factors now classified as pathological has likely contributed to people increasingly perceiving their lives as being threatened by real but minor risks or even entirely fictitious dangers (e.g., cell phones, low radiation) (Le Fanu, 2012).

2. WHO's notion of mental health

Numerous organizations engaged in mental health promotion adopt the WHO's definition of mental health, and we will commence our analysis by discerning whether it aligns with the aforementioned requirements. The WHO's definition understands mental health as more than the absence of disease, but, rather, as a state of well-being in which individuals realize their abilities and can cope with normal life stress and engage in productive work to contribute to their communities. While the shift towards a more comprehensive understanding of health presents significant benefits, it also brings about challenges that warrant scrutiny, especially in the area of public mental health promotion. In particular, doubts might be raised as to what extent it respects the neutrality principle and thus meets requirement (ii).

To explore this matter, let us look closer to the WHO's current definition of mental health, which has its roots in the WHO's concept of health from 1948, where health is defined as a state of complete physical, social, and mental well-being.

> "Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.
>
> Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes.
>
> Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm. People with mental health conditions are more likely to experience lower levels of mental well-being, but this is not always or necessarily the case" (WHO, 2001).

The definition is partly inspired by positive psychology, which grounds mental health in well-being and psychological resources. In this perspective, mental health has an experiential and a functional dimension. The former is about particular experiences (i.e., experiencing a certain level of subjective well-being, i.e., positive emotions and/or satisfaction with life), while the latter is about abilities that enable individuals to develop, handle stress, engage in positive social relationships, and so on. Note that in the WHO's definition, the connection between health and well-being can be interpreted in two distinct ways, namely: (a) health stands in a causal relationship with well-being and (b) health stands in a constitutive relationship with well-being. Most

[2] Due to the complex nature of real-world impacts of policies, Rawls (1988, pp. 251–276, p. 263) rejects the neutrality of effect as impracticable. Moreover, the neutrality of effect does not align with our particular understanding and application of neutrality in this context.

[3] This is not to say that (over)medicalization is restricted to the realm of mental disorders. The same process can occur for somatic conditions that, for instance, used to be considered normal, albeit unfortunate, facts of life, and get increasingly seen and treated as medical issues (e.g., male baldness, erectile dysfunction, menopause). Psychological problems, however, have been particularly prone to this process.

philosophical accounts of well-being would argue that (a) is fairly uncontroversial. Regardless of whether well-being is a matter of the balance between pleasure and pain (hedonism), the fulfillment of desires (desire-fulfillment theory), or the development and exercise of one's natural abilities (perfectionism), health typically positively contributes to well-being, and the absence of health detracts from well-being, as it typically involves the loss of abilities, weakness, discomfort, and diminished sense of meaningfulness, among other negative aspects.

Possibility (b) goes beyond positing a causal relationship and identifies a constitutive relationship between health and well-being.[4] This seems appealing in certain cases. For example, many people have chosen health as a life project on which their sense of identity and well-being depend. In such cases, maintaining and promoting one's health amounts to achieving a life goal that is key for well-being. Changes in health would entail changes in well-being, so that it would not be possible to increase well-being at the expense of health or vice versa. However, possibility (b) encounters obstacles with respect to individuals who have not chosen health as such a key goal. In their case, it is possible to increase well-being at the expense of health or to decrease health without affecting well-being (Keller, 2020).[5] Additionally, if health were considered as constitutive of well-being, then numerous conditions that diminish well-being, such as poverty or homelessness, would be identified as health problems with the risk of blurring that they are also social and political problems.[6]

While these points appear to support option (a), it must be acknowledged that this option lacks specificity. It allows that not all increases in health will lead to increases of well-being, which raises questions as to which types of health promotion to prioritize in order to increase well-being, and it does not identify the specific contribution to well-being that health can provide, for instance, as compared to other goods (e.g., education, wealth).

2.1. WHO's notion of mental health and neutrality problems

The principal issue with this tight coupling of health to well-being is that the implied promotion of a specific conception of a good life, at least when used in mental health promotion, could potentially violate the neutrality requirement. One could argue that the WHO's positive concept of health, while intended to be universally inclusive, is in fact normatively controversial, as it subtly endorses a particular vision of a good life—one that values individual productivity, resilience, social connection, and community contribution. Here are a few points to substantiate this claim.

One important component of the WHO's concept centers on individual productivity, individual resilience, personal advancement, and the realization of one's abilities. While this suggests a strong emphasis on traits highly valued in many societies, even within such societies, there are diverse subcultures that may not align fully with such conception of a good life. For example, in working-class communities, a good life may be more oriented toward the ability to provide stability, security, shelter, education, and food for family members. In many such communities, shared responsibilities and a sense of collective unity often supersedes the importance of individual independence and accomplishments. Instead of individual productivity or resilience, indigenous communities may value higher preserving cultural traditions, and religious communities may prioritize community cohesion, religious observance, or a life devoted to service.

But in that case, the conclusion is that this conception of mental health, qua well-being, implies a particular view of a good life that is *normatively controversial*. The values and assumptions it embodies could provoke disagreement among reasonable individuals possessing standard cognitive abilities, who might have different views on what constitutes a good life. As such, measures seeking to promote mental health while relying on such a conception of mental health would violate the principle of neutrality, unfairly disadvantaging certain individuals or cultures.

There is an additional issue leading to potentially problematic implications. First, while we readily accept that reasonable individuals can have different beliefs about what constitutes a good life, it becomes more challenging to accept this when these disagreements extend to health. Certain groups may not value the specific kind of good life implicated in the WHO's definition, but this carries the risk of being misinterpreted as these groups not valuing health itself. Second, when a global entity like the WHO defines health, it carries a universal implication—it is expected to be applicable to human beings regardless of their beliefs and cultural backgrounds. As the WHO's definition guides policies and research worldwide, misalignment with individual or cultural perspectives can hinder effective implementation of health policies.

3. Alternative accounts of mental health and non-permissiveness

Advocates for the positive health concept could argue that understanding positive health within a more expansive framework than that of the WHO could address the concerns identified in the prior section. They might propose a strategy that maintains some tight link between health and well-being but formulate positive health in a sufficiently broad and permissive manner. While this may still implicitly promote a specific idea of the good life, it would no longer be *normatively* controversial. In what follows, we explore three philosophical accounts that could potentially provide such a solution, given that they utilize a broad, permissive understanding of positive health as grounded in abilities that are central to various ideas of a good life. The main point is that adopting such alternative accounts of health in place of the WHO's definition might adhere to the principle of neutrality, but at the same time, it could violate the requirement of non-permissiveness.

3.1. Nordenfelt, health, and second-order abilities

Unlike the WHO definition, Nordenfelt (1995; 2017) does not begin with well-being, but with a set of abilities. According to Nordenfelt, the abilities that characterize health are those that are necessary for pursuing "vital goals," defined as "the set of goals which are necessary and jointly sufficient for his minimal happiness" (Nordenfelt, 1995, p. 97). Given that there are many circumstances that affect people's ability to reach vital goals, but we still do not consider them unhealthy, Nordenfelt links health to second-order abilities that are necessary to acquire first-order abilities to achieve vital goals.

Nordenfelt defines second-order abilities as follows: "A has a second-order ability with regard to an action F, if and only if, A has the first-order ability to pursue a training-program after the completion of which A will have the first-order ability to do F" (Nordenfelt, 1995, p. 148). Thus, one is not healthy if one lacks the ability to acquire the ability to reach a vital goal. For example, the ability to read is crucial for realizing many of the goals that are considered vital in our society. However, lacking a first-order ability to read is not enough to be considered unhealthy, otherwise, people who never acquired reading skills due to poverty would be considered unhealthy. So a person who lacks the ability to read is only unhealthy if they cannot attain a

[4] Note, however, that the last sentence of the quote suggests a merely causal relationship.

[5] For instance, a significant percentage of men over seventy have prostate cancer but die from other causes before symptoms manifest. While most would agree that these individuals have decreased health due to a pathological condition, the condition does not diminish well-being. Likewise, improving their health by removing the pathological condition would not necessarily increase their well-being.

[6] This, of course, is consistent with considering poverty as a health problem in the sense of being a very important determinant of health and health inequality.

second-order ability to read, despite receiving sufficient support, perhaps in the form of an educational program. Nordenfelt does not present a list of vital goals, but one could assume that goals such as survival, shelter, access to nourishment, minimal economic security, and meaningful social relationships are vital goals regardless of one's preferences and the society in which one is a member. Moreover, Nordenfelt allows that these goals depend on subjective components and individual preferences.

Overall, it appears that using such an account of health in the context of health promotion would not violate the neutrality requirement as it does not appear to imply a particular and normatively controversial conception of the good life. Nonetheless, the inclusion of subjective elements leads to serious challenges. The account either (a) leads to counterintuitive results and violates the non-permissiveness requirement or (b) breaches the neutrality requirement.

As to (a), imagine a dedicated e-sports player who has set a goal of achieving the first-order ability to mentally rotate a large number of Tetris blocks in under 2 s. Despite optimal training opportunities, he never develops this ability. As his life and sense of identity are largely centered around the pursuit of this goal, his frustration reaches a degree that deprives him of any happiness and satisfaction with life. In Nordenfelt's view, the e-sports player not only lacks an ability but also health, because he does not possess a second-order ability to achieve at least one of his vital goals. However, this conclusion is counterintuitive, and it is difficult to accept that the lack of extraordinary mental rotation ability is the same as the absence of health. It also seems counterintuitive that an intervention could make him healthy just by changing his goal to rotate the Tetris blocks in under 10 s—something that his current abilities allow. Then the lack of ability would no longer prevent the attainment of a vital goal.[7]

In part, these counterintuitive implications arise because the abilities linked to health are not sufficiently constrained. This means that in the end, the concept of health in Nordenfelt's account is overly permissive and could thus contribute to an expansion in the number of conditions that get classified as "health conditions." But might there be a way to sidestep the problem? Nordenfelt (1995) argues that the vital goals related to someone's minimal happiness cannot be overly ambitious, trivial, or lead to self-harm. To ensure this, he specifies that the vital goals need to contribute to "real" happiness, adding that while this still allows for some degree of individual variation, what real happiness looks like is not a scientific question. While this seems like a sensible solution, specifying what counts as "real happiness" will have to draw on normative ideas about what a good life looks like. But then, we may find ourselves once again facing a possible violation of the principle of neutrality, just like we did with the WHO's definition. Adopting Nordenfelt's perspective on health instead of the WHO's would lead us to a different yet significant dilemma: the approach could either become excessively permissive or, in efforts to avoid permissiveness, it might lose its neutrality.

3.2. Well-being, abilities, and neutrality

According to another account, mental health refers to the psychological abilities that, if developed and maintained, enable individuals to pursue their conception of the good life, *regardless* of what that conception may be. In his work focusing on defining mental disorder, George Graham (2010) has presented a list of basic mental abilities that are necessary for leading a good life. Graham uses a well-known thought experiment by Rawls, the "original position," first devised to help understand the nature of justice. In the original position, one faces a choice between goods but lacks important information about oneself, such as interests, social status, intelligence, income level, etc. The idea is that a rational choice of goods in the original position is impartial: one cannot favor one's own interests and must consider everyone's interests to ensure that one's own interests are met. Therefore, one will select a specific type of goods, "primary goods," that support the pursuit of all kinds of conceptions of the good life.

Although Rawls's discussion is about material and social goods, his theory can be extended to include mental abilities, such as emotional and cognitive capacities necessary for individuals to pursue their own conceptions of the good life. Fundamentally, Graham sees certain mental abilities as primary goods that everyone would prefer in the original position. Graham's list includes the ability to locate oneself spatially and temporally, the ability to understand oneself and the world, the ability to communicate, engage emotionally, and the ability to take responsibility for oneself and make decisions (Graham, 2010, pp. 147–149).

Based on a similar line of thought, Wren-Lewis and Alexandrova (2021, p. 696) present a definition of mental health as "the capacities of each and all of us to feel, think, and act in ways that enable us to value and engage in life." They highlight two relevant abilities. The first ability is the capacity to appreciate life, which presupposes being able to care about certain things, persons, or relationships that one perceives as valuable. The second involves the ability to handle challenges in a flexible way and can be associated with a certain mental flexibility with respect to cognition, emotions, and action.

While it is not possible to fully capture all the nuances of the accounts proposed by Graham, on one hand, and Wren-Lewis and Alexandrova, on the other, they seem to encounter a similar dilemma to the one we observed in Nordenfelt's account. These accounts propose a certain list of abilities that either (a) satisfy the principle of neutrality but are too ambiguous and violate the non-permissiveness requirement, or (b) respect the non-permissiveness requirement but at the price of violating the principle of neutrality.

With respect to (a), both accounts propose a list of mental abilities that seem crucial to mental health but are permissive enough such that they do not obviously violate the neutrality principle. However, they do not provide clear guidelines on how these capacities should be balanced or prioritized, especially given that they might conflict with each other. While advantageous in many respects, these abilities can become problematic when overly developed in individuals. Beyond a certain limit, even abilities that appear unequivocally positive could have a detrimental effect on a person's mental health. For example, while it is certainly beneficial to encourage individuals to value life, valuing life too much to the point of obsession or avoidance of risk could be detrimental to one's mental health. Or consider that while flexibility and adaptability are generally positive abilities, when overdeveloped, they can potentially interfere with the ability to form profound, meaningful relationships. Being so comfortable with change may lead people to become detached from stable elements in their lives, such as long-term relationships or commitments, disincentivizing them from investing time and effort in forming deep connections with others.

This leads to questions about permissiveness. Mental health is not merely about the presence or absence of certain abilities, but also about the balance among them and the thresholds at which both insufficient and excessive manifestation of certain abilities could detract from mental health. Accounts of mental health that focus on abilities ought to provide guidance on the right thresholds with respect to these abilities and on how to achieve and sustain balance among them. If they fail to do so, then they risk being overly permissive. Accounts that underscore abilities, but do not provide clear boundaries for these abilities, could be exploited for overmedicalization and the creation of new "health conditions." At the same time, they might fail to identify cases where certain

[7] See e.g., Schramme (2007) for a detailed discussion. We can also highlight a related issue: Nordenfelt's approach does not consider the possibility that a person's goals may be influenced by their health status. When an individual with health problems adapts and adjusts their vital goals to accommodate their disorder, Nordenfelt's framework would classify them as healthy. However, as their underlying condition does not change, it seems counterintuitive to say that their health has improved.

abilities are developed to an unhealthy extent.

One could argue that the solution to this problem lies in the further specification of the relevant psychological abilities. This, however, would lead to (b), the other horn of the dilemma. Such further specification of the abilities would likely make them too narrow and implicitly imply certain normatively controversial ideas of the good life. It is extremely difficult to eliminate the possibility that rational individuals may be discouraged from pursuing their vision of the good life by possessing (or possessing more of) a particular primary good. Take, for example, the ability to have emotional commitments to others, which Graham includes in his list. A dedicated warrior or a monk may both believe that to achieve their vision of the good life, it would be better for them not to have the ability to form deep emotional commitments to others. In short, the risk is that once we specify and establish a certain benchmark for an ability, like the capacity for emotional engagement, we compromise neutrality.

To conclude, while these accounts make important contributions to our understanding of mental health, deploying them leads to a similar dilemma as the one we have encountered when discussing Nordenfelt's account. At a high level of abstraction, it might be feasible to identify mental abilities that facilitate the fulfillment of all interpretations of a good life, but the result is an overly permissive account that fails to provide guidance for policies and interventions. Attempting to resolve this issue by offering more detailed specifications of the relevant psychological abilities and setting specific benchmarks for these abilities introduces the problem of compromising neutrality.

4. An alternative? The negative concept and its challenges

The resolution to this issue might lie in striking a balance by making a compromise. Rather than using a positive concept of health, which seems haunted by issues with neutrality and permissiveness, we could consider an alternative: adopting a negative, naturalist concept of health. Adopting a negative concept of mental health will perhaps result in less cost-effective health promotion, and it will substantially deviate from current policy approaches, but may in turn avoid being inconsistent with (ii) or (iii) as was the case with the positive concept of health. At least initially, adopting a negative concept would neither be normatively controversial nor overly permissive. This alternative seems to hold potential and is worth examining in greater detail.

Historically, philosophical discussions have focused on a negative concept of health (Radden, 2019; Murphy, 2020). Influential accounts such as Christopher Boorse's "biostatistical theory" (BST) (1975; 1977; 1997; 2014) have combined a negative concept with a naturalist approach holding that "the classification of human states as healthy or diseased can be read off from nature's biological facts without any need for value judgments" (Boorse, 1997, p. 4).[8] According to BST, health is linked to normal function, which is defined as the statistically typical contribution of a subsystem to an organism's survival and reproduction. A disease involves a deviation and is defined as a "statistically abnormal biological dysfunction of a type "hat reduces the survival and reproduction of the organism in its natural habitat" (Boorse, 1997, p. 4; Boorse, 1977, p. 543; Boorse, 2014). The statistical typicality of a contribution is established based on a reference class consisting of the total number of individuals belonging to the same age group and sex (Boorse, 1977, p. 555; Boorse, 2014).[9] [10]

Could employing this naturalistic, negative concept of health successfully mitigate both the problems of neutrality and permissiveness?[11] One might think that as long as it successfully bases the definition of health on objective criteria, it seems capable of resolving both issues. First, it appears relatively straightforward that the BST could avoid being overly permissive: it sets clear boundaries on what constitutes health by defining it in terms of statistical norms. Mitigating the risk of permissiveness and overmedicalization, the labels of "disease" or "disorder" are reserved for conditions that signify a substantial departure from the norm. Moreover, the boundaries defined by the BST are relatively clearly demarcated by the presence or absence of disease, and its account of health does not encompass a wide range of factors, experiences, and conditions (e.g., a person's happiness, fulfillment, or sense of purpose) that can vary greatly among individuals and cultures.

Second, it seems like a negative, naturalistic concept defined along the lines of the BST may be consistent with the principle of neutrality. This is because it defines health in terms of normal functioning, identified without reference to any specific cultural norms or particular conception of what a "good" or "healthy" life should look like. For these reasons, it may appear that such a concept could offer a neutral foundation for public health policies and interventions without promoting normatively controversial views of the good life.

4.1. Neutrality and the naturalist component

To successfully navigate the dilemmas we outlined, the BST needs to provide objective, value-free criteria for health and disease. However, many have argued that the BST falls short in this regard. For reasons of space, we cannot review that entire debate here, which has highlighted a whole array of challenges for the BST (e.g., the reference class problem, the line-drawing problem, the problem of common diseases, and the problems of defining and identifying [dys]functions). In this section, we will outline some of these problems to argue against the BST as an alternative to positive conceptions of mental health.

Consider that the entire approach hinges on whether BST can provide a convincing justification for its choice of reference classes (i.e., sex and age), based solely on neutral facts. This has been thoroughly debated, and BST proponents have not presented a compelling justification so far (Cooper, 2005; Kingma, 2007; Varga, 2015). One could

[8] Of course, other accounts could be used to make the same point. However, the BST might be particularly relevant here, as it was motivated by the discussions surrounding mental disorders and the politicization of psychiatry at the time.

[9] This applies equally to physical and mental health: "the functional idea of health in physical medicine applies as straightforwardly to the mind as to the body" (Boorse, 1976, p. 62). The only difference lies in whether the affected functions are themselves physical or mental: "there is such a thing as mental health if there are mental functions" (Boorse, 1976, p. 63). The existence of mental functions, in turn, requires the possibility of mental causation as well as sufficient uniformity across the human species.

[10] It is worth adding that a recent approach based on the idea of (dys)function can be found in the Research Domain Criteria (RDoC) framework developed by the National Institutes of Mental Health. RDoC's approach is in line with the Boorsean idea that empirical, neuroscientific research will be able to define mental (dys)functions in a value-free manner (Porter, 2019). RDoC identifies six basic domains of human neurobehavioral functioning, which are further divided into numerous constructs to be studied on multiple levels of analysis (e.g., Insel et al., 2010). For critiques of RDoC, see e.g., Weinberger et al. (2015) and Ross and Margolis (2019).

[11] Boorse (1977) observes that the concept of positive health gained popularity alongside the shift towards preventive and community-oriented medicine. However, he contended that this positive concept should be confined to specific areas (e.g., enhancements in fitness and function promoted by various lifestyle movements). Boorse highlights a potential problem with the positive concept: that it "tends to unite under one term a value-neutral notion, freedom from disease, with the most controversial of all prescriptions—the recipe for an ideal human being" (Boorse, 1977, p. 572).

argue, for example, that race, sexual orientation, disease, height, skin color, etc. could be used to delimit a reference class. One could ask: when BST uses a reference class consisting of individuals with a Y chromosome at a particular age to define normal testosterone levels, what counts against using a reference class consisting of blind individuals to define normal vision? The intuitive answer might be that blindness cannot be definitive of normal vision because it is not healthy. Yet, as Kingma (2007, 2019) points out, this would be circular given our goal to define "healthy" via reference classes, and thus cannot be ruled out. Since the BST fails to provide objective criteria for the setting of reference classes, as Kingma argues, their setting threatens to become implicitly value-laden.[12] This is a serious challenge that the BST also cannot get around because it needs reference classes in order to define "normal functional ability" via statistical normality in a certain reference class.

The underlying notion of "function" (Cummins functions), the identification of particular functions, and setting a threshold for normal functional efficiency and dysfunction have also been a matter of debate (e.g., Binney, 2018; Cooper, 2002; Griffiths & Matthewson, 2018; Hershenov, 2020; Rogers & Walker, 2017; Schwartz, 2007).[13] Some of these issues are even more pronounced in the case of mental health, due to the plasticity and multiple realizability of human mental functioning. As Porter (2019) argues via the example of aggression, one cannot assume a species-wide typical level at which aggressive responses contribute to survival and reproduction. The kind and level of aggression will vary substantially based on variables such as gender, race, or cultural environment and social norms. First, the criteria for defining reference classes are highly problematic here, in part due to the intersectionality of relevant factors such as race, class, gender, etc. Second, looking at empirical distributions of certain behaviors within a particular reference class does not make these distributions value-neutral, natural, or healthy; nor can it provide a value-free ground to determine what level of aggression is (dys)functional for whom. At the same time, it threatens to naturalize, and thereby reinforce, gendered or racialized stereotypes, perpetuating patterns of social oppression (Porter, 2019, pp. 12–14).

In sum, without a convincing response to these critiques, we cannot confidently assert that employing the BST's naturalistic, negative concept of health successfully mitigates both the problems of neutrality and permissiveness. First, the BST does not provide a definitive assurance of neutrality: through the selection of reference classes, the identification of functions, and the setting of thresholds, there is a risk that normatively controversial norms and ideas about the good life may inadvertently shape the definition of health. Second, without clear rationale for the choice of reference classes and thresholds, the ability of the BST to avoid permissiveness is uncertain even if it defines health relative to statistical norms.[14]

Certainly, it is conceivable that future iterations of the BST could address these current limitations. But even then, further questions and potential issues will still need to be addressed. For example, one remaining issue is that a negative concept of health deviates significantly from the common or "folk" understanding of health, which tends to be positive in nature. This divergence could create confusion or misalignment between professional health definitions and the general public's understanding of health. For example, in debates about chronic diseases and disabilities, it is now common to claim that individuals can be healthy while also having some functional impairments that may also count as disabilities (CDC, 2020). At the same time, it is increasingly accepted that it is unsatisfactory to categorize individuals with a well-controlled chronic illness as unhealthy (Ventakapuram, 2013). Similar intuitions are supported by recent experimental studies that investigate how individuals understand health and disease, what factors influence their decisions to label a condition as health or disease, and how these judgments vary across different demographic groups (e.g., Varga, Latham, & Stegenga, forthc; Varga & Latham, ms). Among other findings, studies find that lay people deploy a positive concept of health.

A final issue that seems to speak against using naturalist conceptions of health, some argue, is that they tend to promote epistemic injustice (Kidd & Carel, 2019). Epistemic injustice is a mixed epistemic-ethical harm that basically consists in undermining someone in their capacity as a knower (Fricker, 2007). In the case of mental health, *testimonial epistemic injustice* occurs when the testimony of someone living with a mental disorder is taken to be irrelevant based on prejudices against the mentally ill. *Hermeneutical epistemic injustice* occurs, for example, when experiences of illness cannot be made sense of and spoken about due to social taboos, the lack of shared concepts (such as, e.g., postpartum depression), or because certain styles of expression (e.g., emotional versus detached) are associated with incompetence (Kidd & Carel, 2017). Kidd and Carel (2019) argue that because naturalist accounts claim to offer objective criteria for what counts as health or disease, they can discourage clinicians or policymakers from taking people's own perspectives seriously. This exacerbates the challenges faced by individuals with mental disorders, who are already frequently subject to stigma and the consequent epistemic injustices in various social aspects of their lives (cf. also Kidd et al., 2022).

In contrast, a positive concept of health can allow for more variability in people's definitions of health. One context in which this seems relevant are the heated discussions on neurodiversity. The neurodiversity movement advocates for viewing neurological differences as natural variations, challenging the traditional comprehension of conditions like ASD, ADHD, and schizophrenia as disorders or diseases. While the neurodiversity movement considers these conditions as atypical, yet healthy variants of human life (cf. Chapman, 2019; Knox, 2022), deploying a positive concept of mental health can help accommodate such perspectives. For example, whether or not any dysfunction can be identified as the root of ADHD, people with ADHD could still be

[12] Boorse (2014, section IV) responds that the reference classes are not evaluative as long as they are not explicitly chosen for value-laden reasons (i.e., in order to cast homosexuality as something negative). He argues that they are not chosen this way and that his analysis accords with given usage in current medicine. This reply does not solve the reference class problem, though. Even if the current medical concepts or reference classes are not explicitly chosen for value-laden reasons, they can still be implicitly value-laden. Moreover, Boorse argues that medicine does not use other variables than sex and age (in line with the BST), and that hypothetical philosophical alternatives are irrelevant. Binney (2023) argues that clinicians do in fact sometimes make other (value-laden) choices in setting reference classes, and shows that this can have very real, non-hypothetical consequences with the example of osteoporosis.

[13] As the reference class problem follows from Boorse's goal-oriented notion of function (Cummins functions), one way might be to employ an etiological notion of mental functions (Wright functions), as Wakefield (1992) proposes. Mental functions, for him, are traits or behaviours that have been selected for in the evolution of the human species. Wakefield's analysis does not make recourse to statistical normality and thus reference classes. Yet, it encounters a variety of other problems. For example, it has been criticized to be based on an overly simplistic, adaptationist view of evolution. It lacks the resources to account for the variability of adaptive evolutionary responses as well as for exaptations, and it does not determine the relevant time of selective pressure (e.g., Cooper, 2002; Lilienfeld & Marino, 1995).

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healthy in terms of well-being or having certain abilities—which should be furthered by mental health promotion. [15]

5. Concluding remarks

The increased research interest in mental health promotion has been accompanied by increasing political attention to the subject. Among other factors, a better understanding of the role that mental health plays for physical health and improved insight into the socio-economic potential of mental health promotion have led to changes in health policy. While there is agreement that the overall goal of mental health promotion is the maintenance and improvement of positive mental health, this paper argued that adopting a positive concept of health comes with significant challenges needing resolution.

We underscored three prerequisites for ethically and politically justified mental health promotion (i.e., positive mental health concept, respect for neutrality, and avoiding over-permissiveness) and argued that the WHO definition, often employed in mental health promotion, is not consistent with the principle of neutrality. Our subsequent exploration of philosophical accounts revealed that these are either not neutral or overly permissive. In the final part, we considered the alternative of adopting a negative and naturalist concept of health, but ultimately concluded that this alternative does not provide a more satisfactory outcome.

The overall picture that emerges is that some key premises about using a positive concept of mental health may need reconsideration. If we want a concept of mental health that can effectively inform policy decisions, it may be necessary to accept certain compromises that do not fully resolve the issues discussed here. Should this prove to be the case, then the need for additional research to determine the most suitable compromises becomes evident.

CRediT authorship contribution statement

Somogy Varga: Conceptualization, Writing – original draft, Writing – review & editing. **Martin Marchmann Andersen:** Writing – review & edting. **Anke Bueter:** Writing – review & edting. **Anna Paldam Folker:** Writing – review & edting.

Data availability

No data was used for the research described in the article.

[15] One could add that Boorse distinguishes between theoretical and practical disease and health concepts and argue that his analysis focuses on a value-free concept of disease that features in theoretical medicine. He recognizes that when the theoretical concept is applied in practical health settings, it must be supplemented with values, leading to partially evaluative "disease-plus" concepts (e.g., "diseases that should be treated") (Kingma, 2012). So proponents of the BST could argue that the issue does not lie with the naturalist analysis itself, but rather with the practical concept of health, which can lead to various forms of epistemic injustice. In other words, the naturalism framework is not problematic, but the application of these concepts in real-world contexts can result in injustices, particularly in how knowledge about health is understood and acted upon. While it's challenging to thoroughly address this issue, there are two key points that argue against the BST proponents' claim. Firstly, Boorse has not provided a detailed explanation of the distinction between the theoretical and practical concepts of health, nor has he clarified how the theoretical concept influences the practical one. Without this detailed account, it's difficult to determine the extent to which the theoretical concept shapes the practical one. If the influence of the theoretical concept on the practical concept is significant, then it's possible that the theoretical concept could indeed be contributing to the problem. This suggests that the naturalist analysis might play a role in creating or exacerbating issues in the practical application of health concepts, potentially leading to misunderstandings or misapplications in healthcare practices and policies.

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