CHAPTER 1

Positive Mental Health—What Is It, How Is It Recognized, and Can It Be Achieved?

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INTRODUCTION

Since its birth, psychiatry has struggled against a conceptual blur that has, with time, contributed to forming its inmost identity. What are mental disorders? Do they “really” exist? Is there any kind of normality in the functioning of the mind? What is mental health? Is it different from psychiatry? And so forth. All of these questions are regularly debated in the media, from specialized literature to the mainstream press.

Recently, a new concept has emerged, that of positive mental health. It is perhaps more than just an item added to a long list. Indeed, from its very beginnings, psychiatry has dealt with mental distress. The notion of positive mental health seems to have upset the paradigm: the implicit objective is now to make people happy, rather than solely dealing with their distress. This difference is more than symbolic, and this is what we are going to discuss in the present chapter.

WE ALL WANT OUR YOUNG PEOPLE TO BE HAPPY

At first sight, positive mental health and its implicit positioning toward a search for happiness seems to sum up the very nature of the aims of mental health professionals: we want children and teenagers to be well and happy with their lives. And because young people are so important in society, because they are the future, and because they are cherished, it is natural for everybody to want the best for children and adolescents.
In fact, things are not so simple, and this is one important aspect of clinical practice. The feelings we have for our patients and the feelings parents and caregivers have about their young people is extraordinarily complex and ambivalent. In the depths of our emotional lives, it is not always easy to disentangle positive and negative emotions and intentions. It can be recalled that this was discussed in the excellent paper by Daniel Winnicott, “Hate in the Counter-Transference” (Winnicott, 1994). Even mothers have many reasons to hate their babies:

“The baby is an interference with her private life, a challenge to preoccupation. [...] He is ruthless, treats her as scum, an unpaid servant, a slave. She has to love him, excretions and all, [...] His excited love is cupboard love, so that having got what he wants he throws her away like orange peel. [...] At first he does not know at all what she does or what she sacrifices for him. Especially he cannot allow for her hate. [...] He is suspicious, refuses her good food, and makes her doubt herself, but eats well with his aunt. After an awful morning with him she goes out, and he smiles at a stranger who says: “Isn’t he sweet!” [...] He excites her but frustrates - she mustn’t eat him or trade in sex with him.”

There are even sociological reasons to hate babies and children. One day they will become adults with power, and when that time comes, we will be old—and at their mercy.

But let us temporarily forget these unwelcome preliminaries and concentrate on the general consensus: we all want happiness for our youngsters.

THE QUESTION OF HAPPINESS

But what does “happiness” mean, after all? Surprisingly, this common and fascinating word raises numerous problems. Philosophy has tried to address most of them over two millennia, and some answers have been proposed (Haybron, 2011). They consist less in definitive solutions than in a number of interesting views, among which are a certain number of theories of happiness. Three appear to be most influential.

The first is hedonism. According to hedonism, happiness comes from the predominance of pleasant experiences over unpleasant ones.

The second theory is subtly but importantly different. It is the emotional state perspective. According to this theory, happiness is related to our emotional state, and there can be a gap between feeling pleasure and being in a positive mood. For instance, an anxious person who eats a tasty cake to deal with his/her anxiety will obviously experience some pleasure. But it is possible that this person, at the same time, will not experience happiness because of his/her ever-present anxiety and, perhaps, because of added guilt. Negative emotions can emerge from pleasure.
The third theory relates to life satisfaction, and here we clearly have another perspective. Life satisfaction is a personal, introspective, and global judgment about what a human being considers he/she is and has done with his/her life. And this may or may not be related to pleasure or experiencing positive emotions. A classic example is the emblematic figure of the ill-fated and unrecognized artist. Hopeless, misunderstood, and melancholic all of his/her life, he/she obtains recognition for his/her genius only at the end of his/her life, if not posthumously.

It is therefore difficult to be clear about happiness. And because of the considerable theoretical diversity, some authors have proposed very extreme opinions. For instance, the opinion that happiness simply does not exist. This is A. Schopenhauer’s message: do not try to achieve happiness, just avoid unnecessary suffering (Schopenhauer, 2009).

WHAT PSYCHOMETRICS TELL US ABOUT HAPPINESS AND WELL-BEING

Even if they are obviously very normative, some authors have devised instruments devoted to the measurement of happiness or well-being. With these instruments it is possible to carry out statistical analyses of happiness. In particular, it is possible to determine whether or not happiness is a unidimensional concept, or whether it is merely the opposite of distress. Of course, considering the complexity of the concept, any results should be considered very cautiously.

Regarding the dimensional structure of happiness, some studies are in favor of an approximate unidimensionality. More precisely, as has been seen above, there are indeed several dimensions in the concept of happiness (such as autonomy, control of the environment, personal growth, positive relationships with others, purpose in life, self-acceptance, etc.), but these dimensions are positively correlated, so that a model with a single second-order super-factor has an acceptable fit (Ryff & Keyes, 1995; Stones & Kozma, 1985). In other words, from a statistical point of view, happiness is not a pure concept, but it is made up of several facets that have a common core, and this common core can be measured.

To the question: “is happiness simply the opposite of distress?” the answer is clearly “No.” Although measurements of happiness are negatively correlated with measurements of distress in most studies, the correlation is moderate at best. Moreover, the patterns of correlations between positive and negative sub-dimensions of happiness and distress can be complex. For instance, a person is unlikely to be both satisfied with life and depressed, but may be satisfied and anxious (Headey, Kelley, & Wearing, 1993). On the other hand, some covariates can have specific effects on positive or negative measurements: socioeconomic
status (SES) seems to have, in absolute value, a greater influence on “ill-being” than on well-being. The reverse is true for having a well-developed social network, while health tends to be more markedly associated with ill-being (Headey, Holmstrom, & Wearing, 1985).

Recently, UNESCO (Child Well-being in Rich Countries, n.d.) has used psychometric measurements of this kind to provide a comparative overview of child well-being in wealthy countries.

WHAT POPULATION-BASED STUDIES TELL US ABOUT CHILD WELL-BEING

The UNESCO study is interesting, because in the same document it provides objective socioeconomic indicators alongside more subjective measurements of children’s life satisfaction obtained from a self-administered questionnaire (children aged 11 to 15).

The socioeconomic indicators were distributed across five dimensions: material well-being, health and safety, education, behaviors and risks, and housing and environment. A series of 29 countries—the United States, Canada, and 27 European nations—were ranked according to these dimensions.

The main results are summarized as follows:

- The Netherlands and most Scandinavian countries are the top-ranking countries.
- The Baltic countries, Greece, Romania, and the United States are the lowest-ranking countries.
- The relationship between per capita Gross Domestic Product and overall child well-being is not clear. Indeed, the Czech Republic is ranked higher than Austria, Slovenia higher than Canada, and Portugal higher than the United States.
- The consequences of child development in the early years are likely to have substantial and sustained effects on the well-being of children.

The concept of well-being appears to be potentially useful, especially to help in public policy decision-making as suggested by the last bullet point. This is one of a number of possible explanations for the rise of “positive psychology” at the start of the 21st century.

POSITIVE PSYCHOLOGY

According to some of its figureheads, positive psychology is defined as “the scientific study of positive human functioning and flourishing on multiple levels that include the biological, personal, relational,
Institutional, cultural, and global dimensions of life.” (Seligman & Csikszentmihalyi, 2000).

From this definition, positive psychology is clearly not a philosophical movement, but a scientific discipline. It is a de facto branch of psychology: the notions of “functioning” and “flourishing” are related to behavior and to the mind, respectively. From a more institutional point of view, it can be noted that Martin Seligman, a leader in the domain, was the president of the American Psychological Association in 1998.

There are postulates that structure positive psychology. In particular, certain emotions and traits that can be considered “positive” and others that are considered “negative”. For instance, joy, relief, and pride are positive emotions, while optimism and kindness are positive traits. On the other hand, sadness and anger are negative emotions, while impulsiveness is a negative trait. Positive psychology thus uses methods from fields as different as neuroscience, cognitive science, genetics, or epidemiology to study “positivity.” The number of papers that have been published in the international literature on the subject during the last two decades has been particularly impressive.

Alongside these scientific studies, therapeutic interventions have been developed to promote positive feelings, positive behaviors, or positive cognitions. Some encouraging results have been published concerning the evaluation of these interventions (Sin & Lyubomirsky, 2009).

Positive psychology appears ultimately as the crystallization of ancient traditions of promoting happiness and well-being. This crystallization has been made possible in the last few decades by the catalytic effect of modern and high-tech sciences, such as neuroscience, genetics, and other quantitative approaches. The advent of “positive psychology” can also be considered the movement of emancipation of psychology from psychopathology and psychiatry. This is explicit in many texts, such as this passage by Seligman (2004): “for the last half century psychology has been consumed with a single topic only - mental illness.”

This is not the first occurrence in which medicine, in its most narrow sense, has been extended to a broader concept. The emergence of the notions of health and mental health, as promoted by WHO, has followed similar logic.

WHO AND THE DEFINITION OF HEALTH

For a long time, health was considered the opposite of being in a pathological state. This was brilliantly described in a famous sentence attributed to the surgeon René Leriche in 1936: “Health is life, lived in the silence of the organs.”

I. CONCEPTUAL APPROACHES
In 1946, WHO proposed a radically different perspective: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (Constitution of the World Health Organization 1946, 2002). This position is much more ambitious: health no longer derives from the absence of problems (silence of the organs) but from a positive state (complete physical, mental, and social well-being). Many have criticized such a complete change. The most provocative denunciation that I have heard of the historic WHO definition of health was during a PhD viva, some years ago, when a colleague said that “complete physical, mental, and social well-being” could only occur after an orgasm or a shot of heroin.

Perhaps because of these problems of interpretation, in 1986 WHO proposed some elements of clarification on its definition of health: “To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.” (WHO: The Ottawa Charter for Health Promotion, 2015).

Here WHO comes up against the problems we pointed out in the previous section on the philosophy of happiness. There are several distinct theories of happiness, and WHO has tried to combine at least two of them, which is not an easy task. The original definition in 1946 was oriented toward the search for some kind of ultimate pleasant experience, while the 1986 definition emphasized the new notion of satisfaction. But satisfaction is an emotion related to the fulfillment of a need, and it is not clear why an emotion of this sort should be included in the definition of health. It is even more surprising to note that the 1946 definition corresponds to a very exhilarating feeling, while satisfaction, at the core of the 1986 definition, is more closely associated with a peaceful state. Exhilaration and peacefulness are opposite feelings, and they appear here in definitions of the same notion. This raises questions, at the very least.

When considering the definition that WHO gives of mental health, things do not get any simpler. In 2001, in the World Health Report (WHO. The World Health Report 2001 – Mental Health, 2015) it was proposed that:

“Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one’s intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. It is, however, generally agreed that mental health is broader than a lack of mental disorders.

An understanding of mental health and, more generally, mental functioning is important because it provides the basis on which to form a more complete understanding of the development of mental and behavioural disorders.

In recent years, new information from the fields of neuroscience and behavioural medicine has dramatically advanced our understanding of mental functioning. Increasingly, it is becoming clear that mental functioning has a physiological underpinning, and is fundamentally interconnected with physical and social functioning and health outcomes.”
The first part of this text is particularly opaque, but concludes on the need to develop a new area extending beyond the limits of psychiatry. The second part calls on science, in particular neuroscience, for legitimation of the project. And this is surprising. It can even appear somewhat paradoxical that the notion of “mental health” should become valid and relevant because it can be linked to the physiology of the brain. Of course it is against the most basic dualistic position, but this is not necessarily a problem. What is really surprising is that the notion of “health” does not require the same kind of backup at all. It is even the opposite: health is defined without any mention of the body, the organs, or the biology of human beings. To define the notion of mental health, it is the brain that is considered, which is clearly not the case for the notion of health per se.

There are obviously relationships between health, medicine, mental health, and psychiatry that are unclear, and that needs to be considered.

HEALTH VERSUS MEDICINE; MENTAL HEALTH VERSUS PSYCHIATRY

In the previous section we looked at the definitions of health and mental health, and this is not straightforward. Concerning the definition of medicine, it has only the appearance of simplicity. Simplicity is seen in the consensus that exists across dictionaries. If you look in the Oxford or Collins dictionary (for English), or the dictionary of the French Academy of Medicine, “medicine/médecine” is in all cases the science/discipline/practice of preventing, diagnosing, and curing disease.

Because the object of medicine is disease, it is dealing with negativity and not with positivity, and this provides a raison d’être for positive psychology or positive mental health. As discussed above, there is room left for people who wish to develop the notion of well-being instead of simply dealing with “ill-being.”

In fact these definitions of medicine can and should be challenged. Obviously, medicine should deal primarily with patients and not diseases. Indeed, a patient is not defined as a person with a disease.

Georges Canguilhem has admirably explained what a patient is (Canguilhem & Foucault, 1991):

“The doctor is called by the patient. It is the echo of this pathetic call which qualifies as pathological all the sciences which medical technology uses to aid life. Thus it is that there is a pathological anatomy, a pathological physiology, a pathological histology, a pathological embryology. But their pathological quality is an import of technical and thereby subjective origin. There is no objective pathology. Structures or behaviors can be objectively described but they cannot be called “pathological” on the strength of some purely objective criterion. Objectively, only varieties or differences can be defined with positive or negative vital values.”
By this definition, a patient is a person who calls for a doctor and this call is “pathetic” (ie, linked to suffering). A doctor therefore has to respond to this call. This is specifically his/her job, and all the rest (pathology, diagnosis, treatment) should be organized and determined by this goal. In psychiatry, a psychiatric patient is likewise not defined as a person with a mental disorder. Rather, psychiatry is the discipline that has answers to offer to people who call for help because they are suffering in their mind or as a result of their behavior.

This definition has immediate and important consequences. First, medicine (and psychiatry in particular) is not devoted to ensuring happiness. Of course, happiness can be a significant side effect, but it will always be merely a consequence of a call that has been answered. Second, the notion of satisfaction is particularly delicate in medicine. If, as discussed earlier, satisfaction derives from the fulfilling of a need, it is difficult to obtain satisfaction from a doctor. A patient may lack information, an attentive ear, solutions to his/her problems, etc. and can thus be satisfied if responses are provided for these needs. But the actual state of being a patient does not correspond to a need or a lack, and cannot therefore be satisfied. Most often, a patient is not merely a person who has something wrong (ie, a disease) which needs to be corrected, leading to some kind of satisfaction. The call from the patient is in general more complex, in particular in chronic diseases, which are frequent in psychiatry. Sometimes there is a slight ambiguity in patient status and in the way patients experience their symptoms. This is one reason why the notion of cure raises so many problems and why alternative concepts, such as recovery, are currently proposed.

The definition of medicine as an answer to a distress call prevents psychiatry from repeating tragic errors that have been made in the past as a result of straightforward, blind applications of unreasonable theories of happiness. Making people happy despite themselves (ie, without any call on their part) has led to disasters. The way psychiatry has dealt with political opponents in the USSR or with homosexuals in many countries should encourage extreme caution when considering any normative perspective on happiness (King & Bartlett, 1999; Luty, 2014).

Medicine as an answer to a call, however, is also likely to have drawbacks. The call of a patient may be ambiguous or distorted by his/her environment, and the response may be limited. In schizophrenia, for instance, positive symptoms have been stressed, because they are so apparent, while psychiatrists have long neglected the treatment of negative symptoms, which are now considered a major issue in the patient’s existence. Likewise, in attention deficit hyperactivity disorder (ADHD), hyperactive and impulsive symptoms have been the focus of clinicians, while inattention, because it may be less problematic in daily life, has been somewhat neglected. Yet it is now acknowledged that their role in patient prognosis is crucial (Pingault et al., 2013).
THE PARTICULAR NATURE OF CHILD AND ADOLESCENT PSYCHIATRY

In his definition of what a patient is, G. Canguilhem added a footnote: “It is understood that we are not dealing here with mental illnesses where the patients’ ignorance of their state often constitutes an essential aspect of the disease.” Hence, for this author, a psychiatric patient should perhaps not be defined in the same way as a patient with a somatic disorder. However, this opinion of psychiatric patients as often being “ignorant of their state” is a rather preconceived idea. Of course we need to remember that The Normal and The Pathological was published in 1966, and that the representations and realities of psychiatry were very different at that time. It is now well-known that even if there is a deficit in self-awareness in some psychiatric disorders, most patients are able to reliably self-report on how they assess their existence. This is even true for schizophrenic patients with significant executive impairment (Baumstarck et al., 2013). Conversely, it is a well-known fact today that denial is not rare in somatic diseases, especially among people with cancer (Vos & de Haes, 2007). Thus, the definition proposed by Canguilhem could and should also apply to psychiatric patients, except perhaps when the patient is experiencing the most intense levels of psychotic episode.

This solves the question for adult psychiatry, but unfortunately not for child and adolescent psychiatry. Indeed, many young patients with autism or ADHD who see a child and adolescent psychiatrist are there because of their parents or because of the school, but not because of a personal appeal resulting from suffering in their minds or because of their behavior. This is a real ethical issue that has so far not drawn enough discussion, and for which we have no definite solution. One proposal would be to consider that the “patient” in child and adolescent psychiatry is a community and not a person. The call leading to the consultation emerges from a group, and even if it is a child or an adolescent who actually presents, it is the group as a whole who is suffering and will even sometimes participate in, and benefit from, the treatment.

SYNTHESIS

From a philosophical point of view, happiness is a complex topic. Hedonism, the emotional state perspective, and life satisfaction are leading theories of happiness. These three theories are only partly compatible.

For a long time, many have found happiness in the development of positive emotions, traits, or behaviors. This was already the case in ancient Greece. In the 16th century, Spinoza stressed the need to favor joyful passions and shun sad ones (Spinoza, The Ethics IV, proposition 41). Positive psychology is a scientific update of these traditions.
Positive mental health has been developed to escape limitations inherent in psychiatry, but the concept suffers from inconsistencies. By construction, psychiatry addresses ill-being. Mental health is an attempt to bring together the traditional psychiatric approach and the more recent perspective of positive psychology. From an epistemological point of view, this fusion is frail for the following reasons:

Medicine is not an art or a science that treats diseases, but the discipline that produces doctors who respond to their patients’ call. Medicine is not designed to make patients happy. Medicine addresses the existential shift that comes from being a patient, and this is not reducible to pain, suffering, or ill-being (even if in practice, it is essential to treat pain, suffering, ill-being, and disease).

Psychiatry is the medical discipline that proposes answers to people who call for help because they are suffering in their mind or as a result of their behavior. Because of the nature of mental disorders, patients can sometimes find it difficult to ask for help. This definition of psychiatry should therefore be considered as a principle and not a rule.

CONCLUSION

The object of medicine and psychiatry is distress in human beings. Distress in body or mind can be so intense that there is a need to call for help.

Across the centuries, physicians and scientists have progressively identified diseases and disorders from regular patterns of symptoms and biological abnormalities. Physicians are so fascinated by diseases that, with time, medicine has become the discipline that diagnoses and treats diseases instead of the discipline that treats patients.

Because of this shift, and because physicians are more inclined to prefer the great pleasure and glory that comes with successful treatment to the silent efficacy of a good prevention intervention, today there is a gap between the expectations of society concerning medicine, and what is offered by physicians in general and psychiatrists in particular. Because of this gap, new concepts have been introduced to challenge the powerful and well-established field of medicine. Health, mental health, and positive mental health are among these concepts. Unfortunately, their definitions raise many issues. Today, there is a risk that a good initiative might fail, particularly because there is no single definition of happiness, and because happiness is not the mere opposite of distress. Solid societal legitimacy is required to be able to determine what is “good” for people, and health care providers do not have this legitimacy. This is particularly true in the field of psychiatry.

Health care providers, whether they are physicians or not, should thus restrict themselves to the treatment of distress. But that is not to say that medicine and psychiatry do not need to evolve. Caring for the patient instead of being obsessed with disorders, and investing more in prevention are two urgent needs.
References


I. CONCEPTUAL APPROACHES