Suggested Reading

Psychiatry and Human Flourishing

Adapted by Margaret Chisolm from talk given by Paul McHugh at Johns Hopkins Psychiatry Grand Rounds 2013; a version of which is being prepared for submission to peer-reviewed journal

Medicine is a public trust aimed at improving individual health through the elimination of disease and illness. It includes prescriptions, cures, remedies, and repairs expressed in all the specialties of medicine and surgery. Hygiene entails practices protecting and supporting individual and public health. They include rules, customs, laws, and expectations governing a community or enterprise in ways conducive to health. Heath entails an evaluative normative ideal approximated in the world of judgments, as does truth. The judgments themselves derive from standards of human living where sound features of body and mind lead to survival, procreation, and the vital and happy flourishing of the person in society.

Historically, psychiatry has been concerned primarily with improving the health of patients suffering from a range of psychiatric conditions, a focus that is rightly placed. Psychiatrists need to work towards curing psychiatric diseases, interrupting problematic behaviors, providing guidance around temperamental vulnerabilities, and creating meaning in life's challenges and losses. However, there are aspects of problematic mental life that extend beyond the psychiatric conditions themselves and it would be helpful to start a conversation over how we psychiatrists link the domains of mental illness, mental hygiene, and mental health. How do we identify a flourishing, healthy mind: as something more than a mind without illness? And do these concepts matter to practice and research.

Are there issues implicit in our treatment of patients that go beyond the ways we address their specific psychiatric conditions? If so, can we make these more explicit?

This means entering the domain of public health where matters relating illness to broad conceptions of the social and physical environment are studied. Certainly the recent and splendid book published by Oxford Press and edited by William Eaton, *Public Mental Health*, provides many examples of what we have learned from epidemiologic and population studies about the extended risks that affect mental life and the treatment of mental disorders.For example, it is well known that using cannabis increases the risk of relapse in patients who have had alcohol dependence even after a sustained remission. (2005 Aharonivich). We were taught by Julian Leff and George Brown to deal with domestic 'expressed emotion' (E.E.) so as to sustain schizophrenic patients in their remissions (2012 review reference: Ameresha and Venkatasubramanian). We have long been aware (2008 ref. Miller and Hemenway) of the risks linking gun ownership and suicide that have been recently in the news with the dreadful Charleston massacre. We all know that "partner reduction" is the major factor controlling sexually transmitted disorders (STDs) with all their psychological misery (Wilson 2004). The risks and benefits for behavioral issues found within a person's "social network" (revealed brilliantly by the Framingham Heart Study (Christakis and Fowler, 2008) have also been described and discussed here before.

And yet is there not something more for us? Must we presume that mental health will emerge simply by our eliminating mental disorders or is there something more about health we need to consider?

Certainly we believe so about physical health. We know that physical health exists in a functional relationship with the environment, and doctors interested in preventing diseases and in restoring health are actively engaged in describing aspects of the life environment not only as a source of disease but as a place where better management of living produces continuing health.

The term "hygiene" identifies principles governing the preservation and enhancement of health by practices and environmental manipulations conducive to it. And "hygiene" is not a trivial idea as we at Hopkins are made aware now every day in the hospital. Johns Hopkins University Professor Peter Pronovost has made an international reputation and received a MacArthur Award from exemplifying and prescribing "hand hygiene" (essentially frequent hand washing) to us all with splendid and demonstrable advantages to our patients and ourselves. And at Johns Hopkins, as elsewhere, "hygiene lives" in both concept and precept.

But what about mental hygiene? Can we make the same claim for it? Certainly mental health and mental illnesses, like physical health and physical illness, must exist in a functional relationship with one another. Dealing practically with that interaction must represent issues of mental hygiene. The Department of Mental Health in the Johns Hopkins Bloomber School of Public Health was originally designated the Department of Mental Hygiene. Does the title change suggest that we may be losing some ways of specifying and distinguishing aspects of our medical enterprise?

If mental hygiene and physical hygiene exist as analogous concepts, are we as sure of what we mean by "mental health" – the condition to be sustained and supported by mental hygiene – as we may be of "physical heath" where we see morbidity and mortality avoided and the energy sustained by physical hygiene? It is strange to have to ask psychiatrists what they actually mean by "mental health?" Is it an observable property, or is it like 'truth' an ideal approximate rather than perfect in its examples and expressions?

This is not a new question, Aristotle taught that constraints exist on what can be called 'healthy' activity and in his two treatises on "action" (the "Nicomachean Ethics" and the "Eudemian Ethics") describes flourishing in life in terms of expressed 'happiness': defining happiness as derived from "activity of perfect life in accordance with perfect virtue" ("perfect" meaning "complete" rather than "supreme"). (Kenny, p 6)

Dr. Aubrey Lewis addressed the issue of mental health in a lecture (to the British Sociological Association no less) entitled, "Health as a Social Concept," But if social concepts define mental health, what should psychiatrists notice social scientists to be saying about it?

Dr. Corey Keyes, a sociologist at Emory (in a 2007 article in the *American Psychologist* entitled, "Promoting and Protecting Mental Health as Flourishing") holds that mental illness and mental health actually form two separable continua in the population, challenging assumptions that the presence of mental health is but the absence of mental illness. He claims that only the "flourishing" are mentally healthy and only a small proportion of people free of common mental

disorders are actually "flourishing." Most people, he claims, are "languishing" whether they have an identifiable mental disorder or not.

Keyes, perhaps to persuade us psychiatrists to take him seriously by genuflecting to our diagnostic methods, produced DSM-like criteria for "flourishing" with A criteria, B criteria, and C criteria. With them Keyes offers a diagnostic formula in which a subject "meets criteria" for "flourishing" if high on at least one criteria of the A group and at least six B and C criteria and "languishing" if low on one criteria of the A group and low on at least six of the B and C criteria. Keyes' criteria list and diagnostic formulae are included in the Appendix. By these criteria, many of our patients, despite being free of mental illness, are clearly "languishing."

If "flourishing" is the issue, what do social scientists say is associated with it or may bring it to pass? These are still more difficult questions – as again Aristotle noted (see Kenny 1992 for a thorough consideration) – but the National Opinion Research Center (NORC) at the University of Chicago has tried to address at least some aspects of the issue.

The NORC investigators' classical work from the 1990s on sexuality in America challenged the Kinsey Reports findings (Laumann et al 1994). NORC's other achievements include their accumulating results from an annual national, household-based survey, the General Social Survey (GSS). For this survey, NORC investigators ask adults about their personal lives and attitudes, including "personal happiness." They ask participants to respond to the item: "Taken all together how would you say things are these days? Would you say you were very happy, pretty happy, or not too happy?" About 30% of participants endorse the response "very happy;" 60% "pretty happy;" and 10% "not too happy." A number of factors seemed to associated with being "very happy"

The scientists then correlate this "personal happiness" item response to various aspects of the survey participants' lives, including work, marriage, social commitments, and religious practice. Of the group that endorsed the "very happy" response, 50% endorsed feeling "very satisfied" in either their employment or their lives as homemakers (whereas only 12% of people dissatisfied in their work reported being happy) and 40% endorsed being married (whereas only 15% of people who were divorced or never married reported being "very happy"). Thus, perhaps there is something about paid or unpaid work satisfaction and a married state that could help people be happy and presumably to flourish. In his recent book, *Coming Apart*, the social scientist, Charles Murray, illustrates these and other correlations of "happiness" with other life characteristics of the participants over time. Taken as a whole, Murray's graphic depictions of the GSS results confer as good an understanding as any of those factors which might be at least correlated with, if not causal of, human "flourishing."

To be sure, correlation may not be cause (and reported "happiness" on the GSS may not be what Keyes means by "flourishing"), but the accumulating GSS resultsare of interest and suggest what might promote to 'mental hygiene' and therefore be encouraged by psychiatrists and others in order to sustain or preserve the 'mental health' of individuals, including our current and former patients.

The classical study by Michael Rutter and David Quinton in the *British Journal of Developmental Psychology* entitled, "The Long-Term Followup of Women Institutionalized in Childhood: Factors Which Promoted Good Functioning in Adult Life" reinforces this

presumption with even better data. This fascinating study should be carefully read and studied by all who reflect on psychosocial contributions to mental health. The Rutter participants are women who had had very distressful childhoods. Many were abused and neglected as children and all were separated from their families and raised in an institution- some from infancy. Follow-up as adults revealed personality disorder and criminality in 30-40% of this cohort. Good psychological outcomes occurred in only 20-25%. The most interesting revelation in the Rutter work was the demonstration that, if the women who were brought up in institutions eventually married "non-deviant " spouses, their risks of personality problems in later life were reduced such that only 4% showed personality disorders, whereas 40% of those who married deviant spouses or were without spouses demonstrated severe personality problems. As Rutter and Quinton searched thoroughly for reasons that predicted who would choose a non-deviant mate (and everyone can think of them), the one (and, believe it or not, the only!) theme that emerged with consistency related to length of "courtship." If their courtship lasted more than six months, some 75% of these women married non-deviant spouses and reaped the psychic advantages. If courtship was less than six months, 65-70% of them tended to marry deviant spouses.

Several crucial points tied to risks and benefits in psychological disorders emerge from this study and explain why it is such a classic. It demonstrates that childhood abuse and neglect increases the risk of disordered adult psychological life, but also shows that these outcomes are not inevitable. At least two social and perhaps interrelated measurable factors reduce these hazards. First, marriage to a non-deviant mate and second, some positive productive experience during schooling that helps women plan their future combine in risk reduction.

A subtle subtext is in play here useful to identify. Sexual relations lead naturally to attachment between people. But this attachment happens just as vigorously with sex between people mismatched temperamentally as between those who 'fit' psychologically and socially. Specifically, sexual attachment and temperamental good fit are distinct psychological phenomena, but only "goodness of fit" in marriage leads to flourishing. At least the Rutter data suggests so.

This study would be difficult to replicate today given that cohabitation before marriage is almost universal amongst young people now. Many hold the well-intentioned belief that cohabitation helps young people in their search for a suitable mate for marriage. This assumption may or may not be true but certainly should be examined.

Patricia Morgan refers to cohabitation as "marriage-lite." Morgan emphasizes that courtship without cohabitation probably affords a less fraught assessment potential to pairs and perhaps greater ease of disengagement when temperament mismatch is recognized by either partner. To borrow from Jerome Kern, with sexual intimacy "smoke gets in your eyes" and cohabitation may produce more sources of 'smoke' to complicate thoughts and plans about commitment and fitness. What economists call "transactional costs" of separation are greater with cohabitation than courting and may explain why it doesn't enhance marital choices. This is a vexed issue socially (and politically) at the moment, but one which deserves further investigation.

Returning then to the GSS and what is associated with being "very happy." It turns out that over two thirds of the GSS participants who endorsed being "very high" in social investment also endorse being "very happy." By social investment it is meant aspects of readiness and efforts at belonging to several groups outside of one's family and profession, giving and volunteering to

people, having informal social interactions, being interested in things like politics or athletics, or things of that sort that involve you with others and their enterprises.

As a brief reminder of the importance of this in the development of sociological ideas, the classical book by Dr. Edward Banfield entitled, *The Moral Basis of a Backward Society* is of interest. In studying a poor Italian village, Banfield noted the prevalence of what he referred to as "amoral familism." By this he meant the social attitudes and actions of the people of that village. They were to maximize the material short-run advantage of their nuclear family and assume that all others will do likewise. The result was community collapse and much social suffering. He contrasted "amoral familism" in the declining Italian town which he called "Montegrano" with the social interactions in a flourishing small rural town in Utah of a similar site and size where most adults joined in some committed activity like working with the Red Cross, raising funds to build a new dormitory at the local community college, and father-son banquets supporting cross-generation work.

Perhaps the most psychiatrically controversial issue from the GSS surveys is that participants who endorse being "high" religious commitment or going to religious services tend to endorse feeling "very happy" compared to those who endorse "no religion." Fifty percent of religious tend to endorse feeling "very happy," where only 20% of the "no religion" respondents do.

What exactly this means is uncertain. Rather than enter this vexed area of religion with "theophobic" psychiatrists, let me note that psychologists have been deeply interested in this matter ever since William James. His book, *The Varieties of Religious Experience*, has been construed as Volume 3 of his *Principles of Psychology* (take note of its subtitle) and there James emphasizes that religion provides a "centering purpose" to human lives in the sense of "mak[ing] easy and felicitous what in any case is necessary" (Varieties p 51). This idea should interest us all.

Psychiatrists cannot and should not prescribe religion But with even a tentative mental hygiene stance psychiatrists should be willing to encourage whatever religious life exists in particular patients, advocating for rather than prescribing it. As well they should encourage studies that might discern causal direction and risk ratios here as elsewhere in the presumably formative social life of patients.

Ultimately if happiness and flourishing are related (as Aristotle assumed), four conditions associated with happiness have emerged from the GSS survey. These are: 1) employment with its satisfaction of action, 2) marital devotion with its mutual support, 3) community contributing with its enhancement of social capital, and 4) religious expression with its sense of centered purposefulness.

Interestingly these "big four" share psychosocial features. Each involves something important. Each demands effort usually extended over time, i.e. "Nothing worth doing comes easily." <u>And</u>, each demands personal responsibility for (or a personal role in) the outcome – a responsibility that brings satisfaction. If social influences do play crucial roles in 'forming' individuals, then these four have the character of personal activities with 'shaping' power.

Once again – and for emphasis – these features remain mostly at the level of association and correlation and without the kind of causal linkages that can be expressed and assured in terms of

risk factors and hazard ratios. That remains in the future – as does so much about mental hygiene – but they suggest connections and directions worthy of investigative study.

Sigmund Freud was said to teach that the satisfactions from love and work were what successful psychotherapy sought and evoked in patients. These social surveys agree that working and loving do seem to matter in life (and may be the most important) but that sharing and praying may combine with the other two in bringing about happiness and perhaps flourishing. We all should look and see.

The world one lives in and acts with contributes – both positively and negatively - to one's mental health just as it does to one's physical health. Hygiene is the scientific identification, quantification, and ultimate advocacy for the better contributions. The prescriptions for mental hygiene will often go beyond those for psychiatric disorders themselves.

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