Wellbeing, Recovery and Mental Health

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CAMBRIDGE UNIVERSITY PRESS

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UNIVERSITY PRESS

University Printing House, Cambridge CB2 8BS, United Kingdom

One Liberty Plaza, 20th Floor, New York, NY 10006, USA

477 Williamstown Road, Port Melbourne, VIC 3207, Australia

4843/24, 2nd Floor, Ansari Road, Daryaganj, Delhi - 110002, India

79 Anson Road, #06-04/06, Singapore 079906

Cambridge University Press is part of the University of Cambridge.

It furthers the University's mission by disseminating knowledge in the pursuit of education, learning and research at the highest international levels of excellence.

www.cambridge.org
Information on this title: www.cambridge.org/9781107543058

First published 2017

Printed in the United Kingdom by Clays, St Ives plc

A catalogue record for this publication is available from the British Library.

Library of Congress Cataloguing in Publication data
Names: Slade, Mike, editor. | Oades, Lindsay G., editor. | Jarden, Aaron, editor.
Title: Wellbeing, recovery and mental health / edited by Mike Slade, Lindsay Oades, Aaron Jarden.
Description: Cambridge ; New York : Cambridge University Press, 2016. | Includes bibliographical references and index.
Identifiers: LCCN 2016021863 | ISBN 9781107543058 (paperback)
Subjects: | MESH: Personal Satisfaction | Psychotherapy – methods | Happiness | Mental Disorders – therapy | Psychiatric Rehabilitation – methods
Classification: LCC RC480 | NLM WM 420 | DDC 616.89/14 – dc23
LC record available at https://lccn.loc.gov/2016021863

ISBN 978-1-107-54305-8 Paperback

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Foreword

"Doctor, I hope you can cure what I have."
"Mister, I hope you have what I can cure."

When I started out as a therapist forty years ago, it was common for my patients to tell me, "I just want to be happy." I replied, "You mean you want to get rid of depression."

Back then we did not have the tools for building well-being and, blinded by Freud and Schopenhauer (who taught that the best humans can ever do is to minimize their own misery), I had not even become aware of the difference. What I had was only the tools for relieving depression. But every person, every patient "just wants to be happy," and this legitimate goal combines relieving suffering and building well-being. Cure, to my way of thinking, uses the entire arsenal for minimizing misery – drugs and psychotherapy – and combines these with positive psychology. Further, being happy is every person's birthright.

And importantly for this volume, learning well-being may circle back and ameliorate misery.

The dirty little secret of biological psychiatry and of clinical psychology is that they both have given up the notion of cure. Cure takes too long, if it can be done at all, and only brief treatment is reimbursed by insurance companies. So therapy and drugs are now entirely about short-term crisis management and about dispensing cosmetic treatments. But progress has come to a dead end at symptom relief. There are no curative drugs, and no drug is in development that I know of that aims at cure. I am by no means a Freudian, but one thing that I think was exemplary about Freud is that he was after cure. Freud wanted a psychotherapy that worked like an antibiotic – killing the bacteria. Freud's talking cure was an attempt to cure patients by ridding them of symptoms forever using insight and catharsis. The decline of the Freudian influence, but much more importantly the stringencies of managed care, has seduced psychology and psychiatry into working only on symptom relief and not on cure.

I've spent a good part of my life measuring the effects of psychotherapy and of drugs, and here's another dirty little secret: almost always the effects are what is technically called "small." Depression is typical. Consider two treatments that are certified by vast literatures to "work": cognitive therapy of depression and selective serotonin reuptake inhibitors (SSRIs, e.g. Prozac). Taking an average over the entire huge literature, for each you get a 65% relief rate, accompanied by a placebo effect that ranges from 45% to 55%. This 65% rate crops up over and over, whether you're looking at percentage of patients or at percentage of relief of symptoms within patients. I call this problem "the 65% barrier."

Why is there a 65% barrier and why are the effects so small?

From the first day I took up skiing until five years later when I quit, I was always fighting the mountain. Skiing was never easy. Every form of psychotherapy I know, every exercise, is a "fighting the mountain" intervention. In other words, these therapies are not self-reinforcing and so they fail to maintain themselves. In general, therapeutic techniques all share the property of being difficult to do, no fun at all, and so they are difficult to incorporate into your life. In fact, the way we measure how efficacious therapies are is by how long they last before they "melt" once treatment ends. Every single drug has exactly the same property: once you stop taking the drug you are back to square one, and recurrence and relapse are the rule.

Many of the positive interventions you will read about in this volume are, in contrast, self-maintaining – they are fun.

In the therapeutic century we've just lived through, the therapist's job was to minimize negative emotion: to dispense drugs or psychological interventions that make people less anxious, angry, or depressed. There is another, more realistic approach to dysphoria, however: learning to function well even if you are sad or anxious or angry – in other words, *dealing with it*.

This posture emerges from the most important (and most politically uncongenial) research finding in the field of personality of the last quarter of the 20th century. This rock-solid finding disillusioned an entire generation of environmentalist researchers (me included), but it is true that most personality traits are highly heritable, and dysphorias often stem from these personality traits. Strong biological underpinnings predispose some of us to sadness, anxiety, and anger. Therapists can modify these emotions but only within limits.

What can a therapist do if the heritability of dysphoria is one cause of the 65% barrier? Oddly enough, therapists can use information from the way that snipers are trained. (I'm not endorsing sniping, by the way; I only want to describe how training is done.) It takes about 24 hours for a sniper to get into position. And then it can take another 36 hours to get off the shot. This means that snipers typically haven't slept for two days before they shoot. They're dead tired. Now, let's say the army went to a psychotherapist and asked how she would train a sniper. She would use wake-up drugs or psychological interventions that relieve sleepiness (a rubber band on the wrist snapping you into temporary alertness).

That is not how snipers are trained, however. To train them, you keep them up for three days, and you have them practice shooting when they are dead tired. That is, you teach snipers to *deal* with the negative state they're in: to function well in the presence of fatigue.

The modifiability of negative emotions and negative personality traits has very strong biological limits, and the best you can ever do with the cosmetic approach is to get patients to live in the best part of their set range of depression or anxiety or anger. Think about Abraham Lincoln and Winston Churchill, two severe unipolar depressives. They were both enormously well-functioning human beings who dealt with their "black dog" and their suicidal thoughts (Lincoln likely tried to kill himself in January 1841). Both learned to function extremely well even when they were massively depressed. So one thing that clinical psychology needs to develop in light of the heritable stubbornness of human pathologies is a psychology of "dealing with it." We need to tell our patients, "Look, the truth is that many days – no matter how successful we are in therapy – you will wake up blue and hopeless. Your job is not only to fight these feelings but also to live heroically: functioning well even when you are very sad."

This volume discusses a new approach to cure that goes beyond this realism.

It is possible that the positive interventions may break through the 65% barrier and move psychotherapy beyond cosmetic symptom relief toward cure.

Psychotherapy and drugs as they now are used are half-baked. At their very, very best they remove the internal disabling conditions of life. *Removing* the disabling conditions, however, is not remotely the same as *building* the enabling conditions of life. If we want to flourish and to have well-being, we must indeed minimize our misery, but in addition we must have positive emotion, meaning, accomplishment, and positive relationships.

The skills of flourishing – of having positive emotion, meaning, good work, and positive relationships – are something over and above the skills of minimizing suffering. These skills are documented to build well-being, and they also may act to relieve psychopathology itself.

This volume tells their story.

Martin Seligman