

05 - 2.5 Normality and Mental Health

2.5 Normality and Mental Health

2.5 Normality and Mental Health There has been an implicit assumption that mental health could be defined as the antonym of mental illness. In other words, mental health was the absence of psychopathology and synonymous with normal. Achieving mental health through the alleviation of gross pathologic signs and symptoms of illness is also the definition of the mental health model strongly advocated by third-party payers. Indeed, viewing mental health as simply the absence of mental illness is at the heart of much of the debate concerning mental health policies. The great epidemiological studies of the last halfcentury also focused on who was mentally ill, and not who was well.

DEFINING MENTAL HEALTH Several steps are necessary in defining positive mental health. The first step is to note that “average” is not healthy; it always includes mixing in with the healthy the prevalent amount of psychopathology in the population. For example, in the general population, being of “average” weight or eyesight is unhealthy, and if all sources of biopsychosocial pathology were excluded from the population, the average IQ would be significantly greater than 100. The second step in discussing mental health is to appreciate the caveat that what is healthy sometimes depends on geography, culture, and the historical moment. Sickling of red blood cells may be lifesaving in New York City, but in the tropics, where malaria is endemic, the sickling of red blood cells may be lifesaving. The third step is to make clear whether one is discussing trait or state. Who is physically healthier—an Olympic miler disabled by a simple but temporary (state) sprained ankle or a type 1 diabetic (trait) with a temporarily normal blood sugar? In cross-cultural studies such differences become especially important. Superficially, an Indian mystic in a state of trance may resemble a person with catatonic schizophrenia, but the mystic does not resemble someone in the schizophrenic condition over time. The fourth and most important step is to appreciate the twofold danger of “contamination by values.” On one hand, cultural anthropology teaches us how fallacious any definition of mental health can be. Competitiveness and scrupulous neatness may be healthy in one culture and regarded as personality disorders in another. Furthermore, if mental health is “good,” what is it good for? The self or the society? For “fitting in” or for creativity? For happiness or survival? And who should be the judge?

MODELS OF MENTAL HEALTH This chapter contrasts six different empirical approaches to mental health. First, mental health can be conceptualized as above normal and a mental state

that is objectively desirable, as in Sigmund Freud's definition of mental health which is the capacity to work and to love. Second, from the viewpoint of healthy adult development, mental

health can be conceptualized as maturity. Third, mental health can be conceptualized in terms of positive psychology—as epitomized by the presence of multiple human strengths. Fourth, mental health can be conceptualized as emotional intelligence and successful object relations. Fifth, mental health can be conceptualized as subjective well-being—a mental state that is subjectively experienced as happy, contented, and desired. Sixth, mental health can be conceptualized as resilience, as the capacity for successful adaptation and homeostasis.

Model A: Mental Health as Above Normal This first perspective differs from the traditional medical approach to health and illness. No manifest psychopathology equals mental health. In this medical model, if one were to put all individuals on a continuum, normality would encompass the major portion of adults, and abnormality would be the small remainder. This definition of health correlates with the traditional role model of the doctor who attempts to free his patient from grossly observable signs of illness. In other words, in this context health refers to a reasonable, rather than an optimal, state of functioning. Yet, as already pointed out, mental health is not normal; it is above average. Some believe that true mental health is the exception, not the rule. Moreover, until recently some believed that mental health was imaginary.

Model B: Mental Health as Maturity Unlike other organs of the body that are designed to stay the same, the brain is designed to be plastic. Therefore, just as optimal brain development requires almost a lifetime, so does the assessment of positive mental health. A 10-year-old's lungs and kidneys are more likely to reflect optimal function than are those of a 60-year-old, but that is not true of a 10-year-old's central nervous systems. To some extent, then, adult mental health reflects a continuing process of maturational unfolding. Statistically, physically healthy 70-year-olds are mentally healthier than they were at age 30 years; for example, Laura Carstensen found through prospective studies that individuals are less depressed and show greater emotional modulation at age 70 years than they did at age 30 years. However, if prospective studies of adult development reveal that the immature brain functions less well than the mature brain, does that mean that adolescents are mentally healthier than toddlers? Are the middle-aged mentally healthier than adolescents? The answer is both yes and no, but the question illustrates that in order to understand mental health we must first understand what we mean by maturity. To confirm the hypothesis that maturity and positive mental health are almost synonymous, it is necessary to study the behavior and emotional states of persons over a lifetime. Although such longitudinal studies have come to fruition only recently, all of them illustrate the association of maturity with increasing mental health. After age 50 years, of course, the association between mental health and maturity is contingent on a healthy central nervous system. The ravages of illnesses like brain trauma, major depression, arteriosclerosis, Alzheimer's, and alcoholism must all be avoided.

The association of mental health to maturity is probably mediated not only by progressive brain myelination into the sixth decade but also by the evolution of emotional and social intelligence through experience. Erik Erikson conceptualized that such development produced a "widening social radius." In such a view, life after age 50 years was no longer to be a staircase leading downward, as in the Pennsylvania Dutch cartoons of life-span development, but a path leading outward. In Erikson's model the adult social radius expanded over time through the mastery of certain tasks such as "Identity versus Identity Diffusion," "Intimacy versus Isolation," "Generativity versus Stagnation," and "Integrity versus Despair." Identity. In such a model the social radius of

each adult developmental task fits inside the next. First, adolescents must achieve an Identity that allows them to become separate from their parents, for mental health and adult development cannot evolve through a false self. The task of Identity requires mastering the last task of childhood: sustained separation from social, residential, economic, and ideological dependence on family of origin. Identity is not just a product of egocentricity, of running away from home, or of marrying to get out of a dysfunctional family. There is a world of difference between the instrumental act of running away from home and the developmental task of knowing where one's family values end and one's own values begin. Such separation derives as much from the identification and internalization of important adolescent friends and nonfamily mentors as it does from simple biological maturation. For example, our accents become relatively fixed by age 16 years and reflect those of our adolescent peer group rather than the accents of our parents.

Intimacy. Then, young adults should develop Intimacy, which permits them to become reciprocally, and not selfishly, involved with a partner. However, living with just one other person in an interdependent, reciprocal, committed, and contented fashion for years and years may seem neither desirable nor possible to a young adult. Once achieved, however, the capacity for intimacy may seem as effortless and desirable as riding a bicycle. Sometimes the relationship is with a person of the same gender; sometimes it is completely asexual; and sometimes, as in religious orders, the interdependence is with a community. Superficially, mastery of intimacy may take very different guises in different cultures and epochs, but "mating-for-life" and "marriage-type love" are developmental tasks built into the developmental repertoires of many warm-blooded species, including ours.

Career Consolidation. Career Consolidation is a task that is usually mastered together with or that follows the mastery of intimacy. Mastery of this task permits adults to find a career as valuable as they once found play. On a desert island one can have a hobby but not a career, for careers involve being of value to other people. There are four crucial developmental criteria that transform a "job" or hobby into a "career:" Contentment, compensation, competence, and commitment. Obviously, such a career can be "wife and mother"—or, in more recent times, "husband and father." To the

outsider the process of Career Consolidation often appears "selfish," but without such "selfishness" one becomes "selfless" and has no "self" to give away in the next stage of generativity. Persons with schizophrenia and individuals with severe personality disorder often manifest a lifelong inability to achieve either intimacy or sustained, gratifying employment.

Generativity. Generativity involves the demonstration of a clear capacity to care for and guide the next generation. Research reveals that sometime between age 35 and 55 years our need for achievement declines and our need for community and affiliation increases. Depending on the opportunities that the society makes available, generativity can mean serving as a consultant, guide, mentor, or coach to young adults in the larger society. Like leadership, generativity means to be in a caring relationship in which one gives up much of the control that parents retain over young children. Good mentors learn "to hold loosely" and to share responsibility. Generativity reflects the capacity to give the self—finally completed through mastery of the first three tasks of adult development—away. Its mastery is strongly correlated with successful adaptation to old age. This is because in old age there are inevitable losses, and these may overwhelm us if we have not continued to grow beyond our immediate family.

Integrity. Finally, in old age it is common to feel that some life exists after death and that one is part of something greater than one's self. Thus, the last life task in Erikson's words is Integrity, the task of achieving some sense of peace and unity with respect both to one's life and to the whole world. Erikson described integrity as "an experience which conveys some

world order and spiritual sense. No matter how dearly paid for, it is the acceptance of one's one and only life cycle as something that had to be and that, by necessity, permitted of no substitutions." It must be kept in mind that mastery of one life task is not necessarily healthier than mastery of another, for adult development is neither a foot race nor a moral imperative. Rather, these sequential tasks are offered as a road map to help clinicians make sense of where they are and where their patients might be located. One can be a mature 20-year-old, that is, healthy. One can be an immature 50-year-old, which may be unhealthy. Nevertheless, acquiring a social radius that extends beyond the person by definition allows more flexibility and thus is usually healthier than self-preoccupation. Generativity by age 40 to 50 years offers a powerful predictor of a contented old age.

Model C: Mental Health as Positive or "Spiritual" Emotions This model defines both mental and spiritual health as the amalgam of the positive emotions that bind us to other human beings. Love, hope, joy, forgiveness, compassion, faith, awe, and gratitude comprise the important positive and "moral" emotions included in this model. Of great importance, these selected positive emotions all involve human connection. None of the emotions listed is just about the self. These positive emotions appear to be a common denominator of all major faiths. Omitted from the list

are five other positive emotions—excitement, interest, contentment (happiness), humor, and a sense of mastery, for a person can feel these latter five emotions alone on a desert island. Negative emotions originating in the hypothalamus such as fear and anger are elaborated in the human amygdala (larger in humans than in other mammals). Of tremendous importance to individual survival, the negative emotions are all about "me." In contrast, positive emotions, apparently generated in the limbic system and unique to mammals, have the potential to free the self from the self. People feel both the emotions of vengeance and of forgiveness deeply, but the long-term results of these two emotions are very different. Negative emotions are crucial for survival in present time. The positive emotions are more expansive and help us to broaden and build. In future time, they widen one's tolerance for strangers, expand one's moral compass, and enhance one's creativity. Whereas negative emotions narrow attention and miss the forest for the trees, positive emotions, especially joy, make thought patterns more flexible, creative, integrative, and efficient. The effect of positive emotion on the autonomic (visceral) nervous system has much in common with the relaxation response to meditation. In contrast to the metabolic and cardiac arousal that the fight-or-flight response of negative emotion induces in our sympathetic autonomic nervous system, positive emotion via our parasympathetic nervous system reduces basal metabolism, blood pressure, heart rate, respiratory rate, and muscle tension. Functional magnetic resonance imaging (fMRI) studies of Kundalini yoga practitioners demonstrate that meditation increases the activity of the hippocampus and the right lateral amygdala, which in turn leads to parasympathetic stimulation and the sensation of deep peacefulness. Positive emotions have a biological basis, which means that they have evolved through natural selection. The prosocial emotions probably reflect adaptations that permitted the survival of relatively defenseless *Homo sapiens* and their extremely defenseless children in the African savannah 1 to 2 million years ago.

Evidence for Positive Emotions. It has taken recent developments in neuroscience and ethology to make positive emotions a subject fit for scientific study. For example, infantile autism, a not uncommon genetic disorder of emotional attachment, was not discovered until 1943 by a Johns Hopkins child psychiatrist, Leo Kanner—in his son. Until then it was not possible for medicine to articulate a positive emotion as basic, but as cognitively subtle, as attachment. Today, the congenital lack of empathy and difficulties of attachment in childhood autism can be recognized by

any competent pediatrician. To locate positive emotion in the mammalian limbic system has been a slow, arduous process. In 1955, James Olds, an innovative neuropsychologist, observed that 35 of 41 electrode placements within the limbic system of rats, but only 2 of 35 placements outside of the limbic system, proved sufficiently rewarding to lead to self-stimulation. Also in the 1950s, neurobiologist Paul MacLean pointed out that the limbic structures govern our mammalian capacity not only to remember (cognition), but also to play

(joy), to cry out at separation (faith/trust), and to take care of our own (love). Except for rudimentary memory, reptiles express none of these qualities. Studies using fMRI demonstrated that when individuals subjectively experience existential states of fear, sadness, or pleasure, blood flow increases in limbic areas and decreases in many higher brain areas. Various studies have located human pleasurable experiences (tasting chocolate, winning money, admiring pretty faces, enjoying music, and experiencing orgasmic ecstasy) in limbic areas—especially in the orbitofrontal region, anterior cingulate, and insula. These diverse structures are closely integrated and organized to help us to seek and to recognize all that falls under the rubric of mammalian love and human spirituality. The anterior cingulate gyrus links valence and memory to create attachment. Along with the hippocampus, the anterior cingulate is the brain region most responsible for making the past meaningful. In terms of mediating attachment, the anterior cingulate receives one of the richest dopaminergic innervations of any cortical area. Thus, the cingulate gyrus provides motivational salience not only for lovers, but also for drug addicts. The anterior cingulate is crucial in directing who we should approach and who we should avoid. Maternal touch, body warmth, and odor via the limbic system and especially via the anterior cingulate regulate a rat pup's behavior, neurochemistry, endocrine release, and circadian rhythm. Brain imaging studies reveal that the anterior cingulate gyrus is aroused neither by facial recognition of friends per se nor by sexual arousal per se. Rather, anterior cingulate fMRI images light up when a lover gazes at a picture of a partner's face or when a new mother hears her infant's cry. Perhaps no area of the brain is more ambiguous in its evolutionary heritage or more crucial to mental health than our prefrontal cortex. The prefrontal cortex is in charge of estimating rewards and punishments and plays a critical role in adapting and regulating our emotional response to new situations. Thus, the prefrontal lobes are deeply involved in emotional, "moral," and "spiritual" lives. From an evolutionary standpoint the human frontal lobes are not different from those of chimpanzees in terms of number of neurons. Rather, it is the frontal lobe white matter (the connectivity between neurons through myelinated fibers) that accounts for larger frontal lobes of humans. This connectivity to the limbic system underscores its "executive" function, which includes the ability to delay gratification, comprehend symbolic language, and, most important, to establish temporal sequencing. By being able to connect memory of the past to "memory of the future," the frontal lobes establish for Homo sapiens predictable cause and effect. Surgical or traumatic ablation of the ventromedial prefrontal cortex can turn a conscientious, responsible adult into a moral imbecile without any other evidence of intellectual impairment. The insula is another part of the limbic system that is only beginning to be understood. The insula is a medial cortical gyrus located between the amygdala and the frontal lobe. The brain has no sensation; humans feel emotion only in their bodies. The insula helps to bring these visceral feelings into consciousness: The pain in one's heart of grief, the warmth in one's heart of love, and the tightness in one's gut from fear all make their way into consciousness through the insula. Both the limbic anterior cingulate and insula appear to be active in the positive emotions of humor, trust, and empathy. The higher apes are set apart from other mammals by a unique neural component called the spindle cell. Humans have 20 times more spindle cells than

either chimps or gorillas (adult chimpanzees average about 7,000 spindle cells; human newborns have four times more; and human adults have almost 200,000 spindle cells). Monkeys and other mammals, with

the possible exception of whales and elephants, are totally lacking in these special cells. These large, cigar-shaped spindle or “von Economo” neurons appear to be central to the governance of social emotions and moral judgment. Spindle cells may have helped the Great Apes and humans integrate their mammalian limbic systems with their expanding neocortices. Spindle cells are concentrated in the anterior cingulate cortex, the prefrontal cortex, and the insula. More recently, scientists have discovered a special group of “mirror neurons” that reside in the insula and anterior cingulate. These neurons are more highly developed in humans than in primates and appear to mediate empathy—the experience of “feeling” the emotions of another. Although the practical applications of this newest model of mental health are still many years away, these findings provide further evidence that the brain and mind are one. In several studies the prosocial biological activity of the anterior cingulate cortex and insula was highest in individuals with the highest levels of social awareness (based on objectively scored tests). In other words, there are not only biological individual differences for negative mental health, but also for positive mental health.

Model D: Mental Health as Socioemotional Intelligence High socioemotional intelligence reflects above-average mental health in the same way that a high intelligence quotient (IQ) reflects above-average intellectual aptitude. Such emotional intelligence lies at the heart of positive mental health. In the *Nicomachean Ethics*, Aristotle defined socioemotional intelligence as follows: “Anyone can become angry—that is easy. But to be angry with the right person, to the right degree, at the right time, for the right purpose, and in the right way—that is not easy.” All emotions exist to assist basic survival. Although the exact number of primary emotions is arguable, seven emotions are currently distinguished according to characteristic facial expressions connoting anger, fear, excitement, interest, surprise, disgust, and sadness. The capacity to identify these different emotions in ourselves and in others plays an important role in mental health. The benefits of being able to read feelings from nonverbal cues have been demonstrated in almost a score of countries. These benefits included being better emotionally adjusted, more popular, and more responsive to others. Empathic children, without being more intelligent, do better in school and are more popular than their peers. The Head Start Program, a program of the United States Department of Health and Human Services that provides education and other services for low-income children and their families, found that early school success was achieved not by intelligence but by knowing what kind of behavior is expected, knowing how to rein in the impulse to misbehave, being able to wait, and knowing how to get along with other children. At the same time the child must be able to communicate his or her needs and turn to teachers for help. Ethologically, emotions are critical to mammalian communication. Because such communications are not always consciously recognized, the more skillful individuals are in identifying their emotions, the more skilled the individual will be in communicating with others and in empathically recognizing their emotions. Put differently, the more one is skilled in empathy, the more one will be valued by others, and thus the greater

will be social supports, self-esteem, and intimate relationships. Social and emotional intelligence can be defined by the following criteria: Accurate conscious perception and monitoring of one’s emotions. Modification of emotions so that their expression is appropriate. This involves the capacity to self-soothe personal anxiety and to shake off hopelessness and gloom. Accurate

recognition of and response to emotions in others. Skill in negotiating close relationships with others. Capacity for focusing emotions (motivation) toward a desired goal. This involves delayed gratification and adaptively displacing and channeling impulse. Some behavioral scientists divide emotions into positive and negative, as if negative emotions were unhealthy (this point of view was emphasized in Model C). This tendency is an oversimplification. As with pus, fever, and cough, so the negative emotions of sadness, fear, and anger are also important to healthy self-preservation. On one hand, positive emotions like joy, love, interest, and excitement are associated with subjective contentment; on the other hand, although negative emotions interfere with contentment, their expression can be equally healthy. Advances in Studying Emotional Intelligence. Over the last 15 years, three important empirical steps have been taken in our understanding of the relationship of socioemotional intelligence to positive mental health. The first step is that both fMRI studies and neurophysiological experimentation have led to advances in our understanding of the integration of prefrontal cortex with the limbic system, especially with the amygdala and its connections. As noted in the previous model, these research advances have brought us closer to understanding emotions as neurophysiological phenomena rather than as Platonic abstractions. The prefrontal cortex is the region of the brain responsible for working memory, and the frontal lobes, through their connections to the amygdala, hippocampus, and other limbic structures, encode emotional learning in a manner quite distinct from both conventional conditioning and declarative memory. The second step has been the slow but steady progress in conceptualizing and measuring "emotional intelligence." Over the last decade measures of emotional intelligence have evolved rapidly. The third advance is the use of videotape to chart emotional interaction. Videos of sustained family interactions reveal that the most important aspect of healthy infant development, of adolescent development, and of marital harmony is how partners or parents respond to emotion in others. To ignore, to punish, and to be intimidated or contemptuous of how another feels spells disaster. Children of emotionally attuned parents are better at handling their own emotions and are more effective at soothing themselves when upset. Such children even manifest lower levels of stress hormones and other physiological indicators of emotional arousal. There are now many exercises in handling relationships that help couples, business

executives, and diplomats to become more skilled at conflict resolution and negotiation. In the last decade, there has also been an increasing effort to teach schoolchildren core emotional and social competencies, sometimes called "emotional literacy." The relevance of these advances in psychology to psychiatry include teaching emotion recognition and differentiation in eating disorders and teaching anger modulation and finding creative solutions to social predicaments for behavior disorders. Model E: Mental Health as Subjective Well-Being Positive mental health does not just involve being a joy to others; one must also experience subjective well-being. Long before humankind considered definitions of mental health, they pondered criteria for subjective happiness. For example, objective social support accomplishes little if subjectively the individual cannot feel loved. Thus, capacity for subjective well-being becomes an important model of mental health. Subjective well-being is never categorical. Healthy blood pressure is the objective absence of hypotension and hypertension, but happiness is less neutral. Subjective wellbeing is not just the absence of misery, but the presence of positive contentment. Nevertheless, if happiness is an inescapable dimension of mental health, happiness is often regarded with ambivalence. If through the centuries philosophers have sometimes regarded happiness as the highest good, psychologists and psychiatrists have tended to ignore it. Subjective happiness can have maladaptive as well as adaptive facets. The search for happiness can appear selfish, narcissistic, superficial, and banal.

Pleasures can come easily and be soon gone. Happiness is often based on illusion or on dissociative states. Illusory happiness is seen in the character structure associated with bipolar and dissociative disorders. Maladaptive happiness can bring temporary bliss but has no sticking power. In the Study of Adult Development, scaled measures of "happiness" had little predictive power and, often, insignificant association with other subjective and objective measures of contentment. It is because of such ambiguity of meaning that, throughout this section, the term subjective well-being will be substituted for happiness. Empirical Evidence. The mental health issues involved in subjective well-being are complicated and clouded by historical relativism, value judgment, and illusion. Europeans have always been skeptical of the American concern with happiness. Only in the last decade have investigators pointed out that a primary function of positive emotional states and optimism is that they facilitate self-care. Subjective well-being makes available personal resources that can be directed toward innovation and creativity in thought and action. Thus, subjective well-being, like optimism, becomes an antidote to learned helplessness. Again, controlling for income, education, weight, smoking, drinking, and disease, happy people are only half as likely to die at an early age or become disabled as unhappy people. A distinction can be made between pleasure and gratification. Pleasure is in the moment, is closely allied with happiness, and involves the satisfaction of impulse and of

biological needs. Pleasure is highly susceptible to habituation and satiety. If pleasure involves satisfaction of the senses and emotions, gratification involves joy, purpose, and the satisfaction of "being the best you can be" and of meeting aesthetic and spiritual needs. Subjective (unhappy) distress can be healthy. As ethologically minded investigators have long pointed out, subjective negative affects (e.g., fear, anger, and sadness) can be healthy reminders to seek environmental safety and not to wallow in subjective wellbeing. If positive emotions facilitate optimism and contentment, fear is the first protection against external threat; sadness protests against loss and summons help, and anger signals trespass. Clarifying Subjective Well-Being. Since the 1970s investigators have made a serious effort to attend to definitional and causal parameters of subjective well-being and thereby address important questions. One such question is: Is subjective well-being more a function of environmental good fortune or a function of an inborn, genetically based temperament? Put differently, does subjective well-being reflect trait or state? If subjective well-being reflects a safe environment and the absence of stress, it should fluctuate over time, and those individuals who are happy in one domain or time in their lives might not be happy in another. A second question, but one related to the first, is what is cause and what is effect. Are happy people more likely to achieve enjoyable jobs and good marriages, or does conjugal stability and career contentment lead to subjective well-being? Or are such positive associations the result of still a third factor? For example, the absence of a genetic tendency for alcoholism, for major depression, for trait neuroticism, and even for the presence of a chronic wish to give socially desirable answers (impression management) might facilitate both subjective well-being and reports of good marriage and career contentment. As with physiological homeostasis, evolution has prepared humans to make subjective adjustments to environmental conditions. Thus, one can adapt to good and bad events so that one does not remain in a state of either elation or despair. However, humans have a harder time adjusting to their genes. Studies of adopted-away twins have demonstrated that half of the variance in subjective well-being is due to heritability. The subjective well-being of monozygotic twins raised apart is more similar than the subjective well-being of heterozygous twins raised together. Among the heritable factors making a significant contribution to high subjective well-being are low trait neuroticism, high trait extraversion, absence of

alcoholism, and absence of major depression. In contrast to tested intelligence, when heritable variables are controlled, subjective well-being is not affected by environmental factors like income, parental social class, age, and education. If subjective well-being were due largely to the meeting of basic needs, then there should be a relatively low correlation between subjective well-being in work and subjective well-being in recreational settings or between subjective well-being in social versus subjective well-being in solitary settings. Because women experience more objective clinical depression than men, the fact that gender is not a determining factor in subjective well-being is interesting. One explanation is that women appear to report both positive and negative affects more vividly than men. In one study, gender accounted for only 1 percent of the variance in happiness but 13 percent of the variance in the intensity of reported emotional experiences.

Other Sources of Well-Being. In some instances environment can be important to subjective well-being. Young widows remain subjectively depressed for years. Even though their poverty has been endured for centuries, respondents in very poor nations, like India and Nigeria, report lower subjective well-being than do other, more prosperous nations. The loss of a child never stops aching. Although achieving concrete goals like money and fame does not lead to a sustained increase in subjective wellbeing, social comparison, like watching one's next-door neighbor become richer than you, exerts a negative effect on subjective well-being. The maintenance of self-efficacy, agency, and autonomy make additional environmental contributions to subjective well-being. For example, elders will use discretionary income to live independently even though this means living alone rather than with relatives. Subjective well-being is usually higher in democracies than in dictatorships. Assuming responsibility for favorable or unfavorable outcomes (internalization) is another major factor leading to subjective well-being. Placing the blame elsewhere (externalization) significantly reduces subjective well-being. In other words, the mental mechanisms of paranoia and projection make people feel worse rather than better. Refined methods of measurement of subjective states of mind have included the Positive and Negative Affect Scale (PANAS), which assesses both positive and negative affect, each with ten affect items. The Satisfaction with Life Scale represents the most recent evolution of a general life satisfaction scale. Most recently the widely validated Short Form 36 (SF-36) has allowed clinicians to assess the subjective cost/benefits of clinical interventions. Because short-lived environmental variables can distort subjective well-being, consensus is emerging that naturalistic experience-sampling methods are the most valid way to assess subjective well-being. With such sampling methods, research subjects are contacted by beeper at random times during the day for days or weeks and at each interval are asked to assess their subjective well-being. This method provides a more stable report of subjective well-being. Finally, to tease verbal self-report from actual subjective experience, physiological measures of stress (e.g., measuring galvanic skin response and salivary cortisol and filming facial expression by concealed cameras) have also proven useful.

Model F: Mental Health as Resilience There are three broad classes of coping mechanisms that humans use to overcome stressful situations. First, there is the way in which an individual elicits help from appropriate others: Namely consciously seeking social support. Second, there are conscious cognitive strategies that individuals intentionally use to master stress. Third, there are adaptive involuntary coping mechanisms (often called "defense mechanisms") that distort our perception of internal and external reality in order to reduce subjective distress, anxiety, and depression.

Involuntary Coping Mechanisms. Involuntary coping mechanisms reduce

conflict and cognitive dissonance during sudden changes in internal and external reality. If such changes in reality are not “distorted” and “denied,” they can result in disabling anxiety or depression, or both. Such homeostatic mental “defenses” shield us from sudden changes in the four lodestars of conflict: impulse (affect and emotion), reality, people (relationships), and social learning (conscience). First, such involuntary mental mechanisms can restore psychological homeostasis by ignoring or deflecting sudden increases in the lodestar of impulse—affect and emotion. Psychoanalysts call this lodestar “id,” religious fundamentalists call it “sin,” cognitive psychologists call it “hot cognition,” and neuroanatomists point to the hypothalamic and limbic regions of brain. Second, such involuntary mental mechanisms can provide a mental time-out to adjust to sudden changes in reality and self-image, which cannot be immediately integrated. Individuals who initially responded to the television images of the sudden destruction of New York City’s World Trade Center as if it were a movie provide a vivid example of the denial of an external reality that was changing too fast for voluntary adaptation. Sudden good news—the instant transition from student to physician or winning the lottery—can evoke involuntary mental mechanisms as often as can an unexpected accident or a diagnosis of leukemia. Third, involuntary mental mechanisms can mitigate sudden unresolvable conflict with important people, living or dead. People become a lodestar of conflict when one cannot live with them and yet cannot live without them. Death is such an example; another is an unexpected proposal of marriage. Internal representations of important people may continue to cause conflict for decades after they are dead yet continue to evoke involuntary mental response. Finally, the fourth source of conflict or anxious depression is social learning or conscience. Psychoanalysts call it “super ego,” anthropologists call it “taboos,” behaviorists call it “conditioning,” and neuroanatomists point to the associative cortex and the amygdala. This lodestar is not just the result of admonitions from our parents that we absorb before age 5 years, but it is formed by our whole identification, with culture, and sometimes by irreversible learning resulting from overwhelming trauma.

Healthy Involuntary Mental Mechanisms. Longitudinal studies from both Berkeley’s Institute of Human Development and Harvard’s Study of Adult Development have illustrated the importance of the mature defenses to mental health.

HUMOR. Humor makes life easier. With humor one sees all, feels much, but does not act. Humor permits the discharge of emotion without individual discomfort and without unpleasant effects upon others. Mature humor allows individuals to look directly at what is painful, whereas dissociation and slapstick distract the individual to look somewhere else. Yet, like the other mature defenses, humor requires the same delicacy as building a house of cards—timing is everything.

ALTRUISM. When used to master conflict, altruism involves an individual getting pleasure from giving to others what the individual would have liked to receive. For example, using reaction formation, a former alcohol abuser works to ban the sale of

alcohol in his town and annoys his social drinking friends. Using altruism, the same former alcoholic serves as an Alcoholics Anonymous sponsor to a new member— achieving a transformative process that may be lifesaving to both giver and receiver. Obviously, many acts of altruism involve free will, but others involuntarily soothe unmet needs.

SUBLIMATION. The sign of a successful sublimation is neither careful cost accounting nor shrewd compromise, but rather psychic alchemy. By analogy, sublimation permits the oyster to transform an irritating grain of sand into a pearl. In writing his Ninth Symphony, the deaf, angry, and lonely Beethoven transformed his pain into triumph by putting Schiller’s “Ode to Joy” to music.

SUPPRESSION. Suppression is a defense that modulates emotional conflict or internal/external stressors through stoicism. Suppression minimizes and postpones but does not ignore gratification. Empirically, this is the defense most

highly associated with other facets of mental health. Used effectively, suppression is analogous to a welltrimmed sail; every restriction is precisely calculated to exploit, not hide, the winds of passion. Evidence that suppression is not simply a conscious “cognitive strategy” is provided by the fact that jails would empty if delinquents could learn to just say “No.” ANTICIPATION. If suppression reflects the capacity to keep current impulse in mind and control it, anticipation is the capacity to keep affective response to an unbearable future event in mind in manageable doses. The defense of anticipation reflects the capacity to perceive future danger affectively as well as cognitively and by this means to master conflict in small steps. Examples are the fact that moderate amounts of anxiety before surgery promote postsurgical adaptation and that anticipatory mourning facilitates the adaptation of parents of children with leukemia. Psychiatry needs to understand how best to facilitate the transmutation of lessadaptive defenses into more-adaptive defenses. One suggestion has been first to increase social supports and interpersonal safety and second to facilitate the intactness of the central nervous system (e.g. rest, nutrition, and sobriety). The newer forms of integrative psychotherapies using videotape can also catalyze such change by allowing patients to actually see their involuntary coping style. REFERENCES Blom RM, Hagestein-de Bruijn C, de Graaf R, ten Have M, Denys DA. Obsessions in normality and psychopathology. *Depress Anxiety*. 2011; 28(10):870. Macaskill A. Differentiating dispositional self-forgiveness from other-forgiveness: Associations with mental health and life satisfaction. *J Soc Clin Psychol*. 2012;31:28. Sajobi TT, Lix LM, Clara I, Walker J, Graff LA, Rawsthorne P, Miller N, Rogala L, Carr R, Bernstein CN. Measures of relative importance for health-related quality of life. *Qual Life Res*. 2012;21:1. Tol WA, Patel V, Tomlinson M, Baingana F, Galappatti A, Silove D, Sondorp E, van Ommeren M, Wessells MG, Panter-Brick C. Relevance or excellence? Setting research priorities for mental health and psychosocial support in humanitarian settings. *Harv Rev Psychiatry*. 2012;20:25.

Vaillant GE. Positive mental health: Is there a cross-cultural definition? *World Psychiatry*. 2012;11(2):93. Vaillant GE. *Spiritual Evolution: A Scientific Defense of Faith*. New York: Doubleday Broadway; 2008. Vaillant GE, Vaillant CO. Normality and mental health. In: Sadock BJ, Sadock VA, Ruiz P, eds. *Kaplan & Sadock’s Comprehensive Textbook of Psychiatry*. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2009:691. Wakefield JC. Misdiagnosing normality: Psychiatry’s failure to address the problem of false positive diagnoses of mental disorder in a changing professional environment. *J Ment Health*. 2010;19(4):337. Ward D. ‘Recovery’: Does it fit for adolescent mental health?. *J Child Adolesc Ment Health*. 2014;26:83-90.

Revision #1

Created 2026-01-04 19:50:32 UTC by Omar Ayman

Updated 2026-01-04 19:50:32 UTC by Omar Ayman