Subjective positive well-being

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Among the seven models of positive mental health so clearly described by George Vaillant in this issue of *World Psychiatry*, the model of subjective well-being, reflecting the positive tone of the World Health Organization (WHO) definition of health, has cross-cultural validity. Actually, Vaillant himself refers to the single-item question "How do you feel about your life as a whole?" as a simple candidate for such a cross-culturally valid measure.

In the WHO Quality of Life Scale (WHOQOL), another "global" question is: "How would you rate your quality of life?". This item is measured on a "bipolar" scale with such answer categories as "poor", "neither poor nor good", and "good" (1). The WHOQOL has been found useful in many cross-cultural studies (1).

In the late 1970s, the Index Medicus accepted self-reported quality of life scales as outcomes in clinical studies. The most frequently used quality of life

scales in the 1980s and 1990s were the Psychological General Well-Being Scale (2) and the Short-Form 36 item health survey (SF-36) (3). Psychometric analyses of these scales identified the factors of physical versus mental health. The WHO (Five) Well-being Index (WHO-5) was then developed for the purpose of measuring positive mental health (4). The WHO-5 includes the following five items: a) feeling cheerful and in good spirits, b) feeling calm and relaxed, c) feeling active and vigorous, d) feeling fresh and rested when waking up, and e) feeling interested in day-to-day activities. The Likert answer categories, which take the past two weeks into account, range from "all of the time" to "at no time". As in the SF-36, the total score on the WHO-5 ranges from 0 to 100, where high scores signify better well-being. Decreased positive well-being as measured on WHO-5 is a sensitive indicator of mental health problems (5), and in clinical trials the goal of treatment is to move the scores up to the mean scores in the general population, i.e. approximately 70 (6).

Subjective psychological well-being or health-related quality of life is often considered to be a rather individualistic, personal or idiographic issue, implying that a cross-cultural definition is very difficult to obtain. As discussed elsewhere (7), subjective well-being might in the first place be considered as a self-reflective, private language in which the person is communicating with herself or himself from the moment when she or he wakes up, perceiving and planning the day, having emotional appetite for starting her or his day. However, studies all over the world have indicated that the WHO-5 items seem to cover basic life perceptions of well-being, allowing this private language to be translated into a simple language of communication (6,7).

In Table 1 of his paper, Vaillant demonstrates that subjective well-being indeed predicted objective mental health with the highest coefficient of correlation when compared to the other models of positive health over a time span of 15 years. The predictive validity of the WHO-5 in a 6-year survival analysis of cardiology patients was also found to be high (8).

Vaillant states that "chemicals can alleviate mental illness but do not improve healthy brain function". The pharmacopsychometric triangle has recently been introduced in trials of antidepressants (6,7,9). The outcomes of pharmacotherapeutic chemicals are hereby triangularized. Antidepressants are not intended to directly treat decreased quality of life, but to treat depressive illness (A) with as few side effects as possible (B). When the balance between (A) and (B) is evaluated by the patients themselves on subjective well-being scales such as the WHO-5 (C), where the goal is to move the scores up into the area of the general population mean scores (6), antidepressants do not, as concluded by Vaillant, enhance mental health beyond this level. Forty years ago, the great American psychopharmacologist L. Hollister (6) taught me that, when treating a 35-year old man for a major depressive episode with an antidepressant, we can move his depression scores down to remission over 6 weeks and then, hopefully, in the relapse prevention continuation therapy, bring him out of the depressive episode. On the other hand, we are not able to then turn the patient into a great violinist if he never had held a violin in his hands prior to treatment.

Within the field of clinical medicine we as psychiatrists do our best to restore the brain functions of our patients suffering from mental disorders, using subjective well-being as an essential goal of treatment within the pharmacopsychometric triangle.

References

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