

tools, has produced most of the vast body of human knowledge on this subject, and still trains professionals specializing in this exact topic. Despite this, other fields have neglected this work and the opportunity for interdisciplinary collaboration. Such neglect has led to approaches already invalidated in philosophy and causing potential harm when applied. Psychiatry must not make this mistake.

As Fava and Guidi point out, the benefit

to psychiatry of incorporating the right conceptions of positive well-being are huge. And so are the costs of getting it wrong.

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## Euthymic suffering and wisdom psychology

In Fava and Guidi's paper<sup>1</sup>, euthymia is defined by "lack of mood disturbances that can be subsumed under diagnostic rubrics", "positive affects" and "psychological well-being". So, good mood is euthymic. But, what about bad mood and suffering which can also *not* be subsumed under diagnostic rubrics? Life is no rose garden. All human beings experience illness, failure, conflicts with others, problems with children or spouse, financial troubles, or legal disputes. It would be a mental disturbance to feel happy under these circumstances. Is euthymia limited to positive affects or happy hours, or should it include all forms of "normal" mood?

That not all hardship and negative feelings automatically qualify as disorder is confirmed by the ICD-10, which provides separate codes (Z codes) for negative life situations such as loss of work, social exclusion, or burnout. If people feel unhappy when burdened by negative life events, this is no mental disorder, but "healthy suffering". It is of great importance not to medicalize such everyday problems<sup>2</sup>. In clinical practice, there are many people who contact medical experts because of healthy suffering. They need a professional evaluation together with some advice.

We need diagnostic criteria for healthy bad mood. Such criteria include situational adequacy of the type and intensity of the emotional reaction, self-appraisal, controllability, compliance with individual and social norms, lack of specific psychopathological signs and symptoms<sup>3</sup>. Healthy persons with normal bad mood display consistency in their behavior and

values, show environmental mastery, self-acceptance, positive relations with others, flexibility, and resilience to go on with daily duties<sup>4</sup>. So, healthy suffering and bad mood should be included in the concept of euthymia.

How can interventions deal with such a broadened concept of euthymia? There are basically four different approaches to foster euthymia.

The first one is to get rid of bad mood by improving well-being through the increase of pleasant activities and experiences<sup>5</sup>. "Regeneration therapy"<sup>6</sup> engages people in positive and self-care exercises, from board games to cultural and social activities, relaxation and make oneself up. Positive effects of these interventions were shown in regard to depressed mood or distress intolerance and the ability to work. The bottom line is that, if you are under stress, you should do something positive for yourself or coddle yourself.

The second approach also aims to counteract bad mood, this time by teaching how to generate positive emotions directly. "Euthymia therapy"<sup>7</sup> teaches the art of enjoyment and experiencing of pleasures. "Well-being therapy"<sup>1</sup> teaches people to focus on constituents of positive mood by self-observation, change of dysfunctional cognitions, and promotion of activities. Studies on these interventions showed positive effects in depressed or psychosomatic patients transdiagnostically. The bottom line is to improve the capacity of the individual to generate positive emotions.

A different type of approach is represented by "mindfulness and acceptance"

based therapies<sup>8</sup>. Their primary goal is not to get rid of negative emotions and cognitions, but instead to change the individuals' relationship to their emotional state, their experiences, and the living context. This is done by encouraging awareness and acceptance of unpleasant feelings through mindfulness practice and cognitive defusion. Commitment and behavior change processes are based on contact with the present moment. Bad mood is accepted and may still be present after treatment. This approach implicitly has a broader concept of euthymia, including bad and positive mood alike. The bottom line is to accept and arrange oneself with something that cannot be changed.

Another approach, which goes in the same direction, is "wisdom therapy"<sup>9</sup>. Life span psychology describes wisdom as a psychological capacity, given to all persons, which is essential in coping with severe, irreversible or unsolvable problems, but also in dealing with daily dilemmas, such as the decision whether to stay at home with a sick child or to go to work. Similar to other psychological capacities, there are about a dozen sub-dimensions, such as recognition of reality (factual and procedural knowledge, contextualism, relativization of problems and aspirations), mastery of emotions (perception and acceptance of emotions, serenity), acceptance of personal limitations (self-relativization, self-distance), clarification and self-assurance of goals and values (value relativism, forgiveness and acceptance of the past, uncertainty tolerance, long-term perspective),

and interactional competencies (change of perspective, empathy).

“Wisdom therapy” provides strategies to translate these sub-dimensions into treatment. There is evidence that it works in patients with severe adjustment disorders<sup>9</sup>. The goal of the intervention is to learn how to deal with bad and good times alike. Euthymia can be defined as a state of wisdom, in which persons feel at ease with themselves and the world, their past, the present and the future, in good and bad times, and do not lose heart and courage in the face of adversities and hardship.

The concept of euthymia should reflect the daily existence of human beings. Happiness is limited to very few moments in

life. Demands, hardship, burdens fill the rest of time. Back pain, heavy work or driving a car in combusted streets do not produce happiness. But there is nevertheless euthymia. The problem of mental illness is that people are overburdened and impaired by daily hassles, while healthy persons have resilience and can deal with bad times.

We should not create the misunderstanding that happiness is the goal to be pursued by our interventions. This can lead to disappointment. Instead, mastery of exceptional and daily burdens and demands, and how nevertheless to “feel OK” (not happy but euthymic), should be the aim.

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## Understanding mood in mental disorders

Mood symptoms and disorders have become a major health issue and the leading cause of disability worldwide. In most branches of medicine, physiology builds the basis of pathophysiology. Psychiatry, instead, lacks a scientifically sound idea of normal functioning. This is particularly true for mood. Psychiatric classification systems conceptualize low mood and mood fluctuations as mere pathologies. Positive psychology constantly confounds optimistic mood with mental health. The paper by Fava and Guidi<sup>1</sup> is a refreshing alternative to these mainstream approaches to mood and its disorders. Importantly, the authors' integrative framework takes mood's adaptive function into account.

The biological mechanisms underlying mood are highly conserved and widespread across species<sup>2</sup>. This suggests that mood has an essential function for survival and reproduction. The brain reward system is an important center of mood regulation. Throughout evolution, this system has increased in relative size from rodents to humans, suggesting that mood is more important in humans than in other animals<sup>3</sup>. What are mood's ancestral and present functions?

From an ecological perspective, mood functions as a slowly changing decision-making mechanism that regulates the individual approach and avoidance behavior. This regulation is based on the expect-

ed reward rate over a longer period of time<sup>2</sup>. Clinicians are used to focus on easily remembered life events in the past – rather than changes in expected reward rates in the future – when exploring the causes of distress and negative emotions. This frequently leads to a misunderstanding of mood states that are detached from any immediate triggering stimulus. A good example is given by seasonal mood fluctuations that are caused by a slow unnoticed reduction or increase of the light reward rate<sup>4</sup>. The American poet E. Dickinson depicted this nature of mood regulation in her poem “As imperceptibly as grief, the summer lapsed away”, linking mood cycles to cycles in the environment.

In scientific terms, mood integrates perceptions and emotional experiences over time. When a person experiences a series of non-rewards or punishments over time, he/she may develop depressed mood. It usually needs an enduring safe situation and repeated rewards to change this negative, risk-averse attitude and to improve expectations about the future reward rate. What is the function of this emotional spill-over? It reflects a specific assumption about the environment, namely that threats and rewards come in cycles. In the Stone Age, a dried up blackberry bush predicted more dried up bushes. A successfully hunted gazelle predicted more hunting luck. In many instances, rewards and

non-rewards still come in cycles and mood is adaptive. However, when applying for jobs or looking for a partner in a big city, the rates of rewards and punishments may not be cyclic but random. As a result, emotional spill-overs can be dysfunctional. Clinicians should help patients to differentiate functional from dysfunctional mood by estimating future reward rates in individual situations.

In humans, mood has a subjective valence. However, mood also regulates more primary cognitive and physiological systems of an organism, such as activity levels and the threshold for detecting rewards and threats, also referred to as cognitive bias. It is important that clinicians distinguish these aspects of mood, because their neural substrates differ. Serotonergic neurotransmission is particularly important for mood as subjective valence and cognitive negativity bias, while catecholamines regulate motivation and activity levels<sup>5</sup>.

Evolutionary psychiatrists explain the high prevalence of low mood by referring to the “smoke detector principle”<sup>6</sup>. This posits that, in the face of uncertainty, mood regulation prefers low mood over high mood because the result of high mood may be death through overlooking risks, while the costs of low mood include missed opportunities and suffering, which do not weigh heavily in the light of evolution. As a result, it is important to detect uncertainty in the