Other studies of antidepressants have reported positive changes in well-being after treatment with sertraline, levomilnacipran ER, venlafaxine and desvenlafaxine. These studies used a variety of scales to measure components of well-being, none of which were as comprehensive as the PWB scales. However, improvements in functions such as vitality, interpersonal functioning, and overall well-being suggest that antidepressants can yield benefits in addition to symptom relief.

There have been several studies suggesting that psychotherapies other than WBT, MBCT and ACT might be useful for reaching euthymia. In one such investigation, Iranian mourners treated with CBT had significantly greater improvements in spiritual well-being (defined as "stability in life, peace, balance and harmony, and feeling a close relationship with self, God, and the environment")[5]. Another study on CBT found greater benefit than an active control on emotional well-being[6], while research on CBT in HIV+ women documented significant increases in psychological and spiritual well-being compared to a psychoeducational control group[7]. Digital delivery of CBT also has been shown to improve well-being. Significant advantages versus control treatments were observed on Warwick-Edinburgh Mental Well-being Scale scores in an online CBT computer program for insomnia[8].

Logotherapy, a treatment focused primarily on helping patients find a sense of meaning in life, has been investigated rarely in randomized, controlled trials. But there is evidence that it can improve well-being. Purpose in life was enhanced in an investigation of individual logotherapy for paralyzed inpatients[9].

Occupational therapy, a treatment with a very different proposed mechanism of action, is another approach that may have benefit in reaching states of euthymia. A large investigation of this therapy versus a no-treatment control reported significant benefits in promoting well-being, including vitality, social functioning, and life satisfaction[10].

It is difficult to compare results of studies on well-being, because different designs and measures have been employed. Fava and Guidi's definitions of well-being and euthymia, and their measurement by the PWB scales, encompass more domains and functions than typically have been assessed in other studies. However, available evidence suggests that therapies that do not posit a specific mechanism of action for enhancing well-being may have some ability to help patients move toward euthymia.

Several explanations for lack of specificity in promoting well-being are possible. Symptoms of an illness such as depression interfere with experiences of well-being, so that any treatment that reduces symptoms may have potential for improving well-being. Furthermore, diverse treatment methods could enhance well-being by operating through common pathways such as effecting the neurobiological processes that underlie subjective experiences of psychological well-being. Unspecified or unmeasured therapeutic influences may be operative in improving well-being (e.g., positive placebo effect, behavioral activation, non-specific elements of all effective psychotherapies).

Although there has been insufficient research to support or refute these possible explanations, there are indications from earlier studies that specific hypothesized mechanisms of action may not be required to convey specific benefits. For example, antidepressants have been found to have a strong influence on negative thinking, a presumed purview of CBT, while CBT improves energy, interest and other symptoms that are targets for antidepressants.

Fava and his associates have been leaders in the development of WBT and in helping clinicians and researchers understand the importance of well-being as a treatment goal. Now, with their call for the pursuit of euthymia, they challenge us to significantly broaden our conceptualization of psychiatric treatment and to search for ways to assist patients in maximizing their functioning in domains such as personal growth, self-acceptance, and purpose in life.

WBT, MBCT and ACT offer considerable promise for reaching such treatment goals. But it is possible that other approaches also could promote well-being and the "platinum standard" of euthymia. Shouldn't all psychiatric treatments pursue euthymia as Fava and Guidi have defined it?

Jesse H. Wright
University of Louisville Depression Center, University of Louisville Medical School, Louisville, KY, USA

1. Fava GA, Guidi J. World Psychiatry 2020;19:40-50.
2. Fava GA, Rafanelli C, Cazzaro M et al. Psychol Med 1998;28:475-80.
3. Weiss LA, Westerhof GJ, Bohlmeijer ET. PLoS One 2016;11:e0158092.
4. O'Malley PG, Balden E, Tomkins G et al. J Gen Intern Med 2000;15:659-66.
5. Khashab AS, Kivi HG, Fathi D. Iran J Psychiatry 2017;12:93-9.
6. Hadinia A, Meyer A, Bruegger V et al. Front Psychol 2017;7:1975.
7. Jensen SE, Pereira DB, Buscher I et al. Health Psychol 2013;32:227-30.
8. Espie CA, Emsley R, Kyle SD et al. JAMA Psychiatry 2019;76:21-30.
9. Julom AM, de Guzman R. Int J Psychol Psychological Ther 2013;13:357-71.
10. Clark F, Jackson J, Carlson M et al. J Epidemiol Commun Health 2012;66:782-90.

DOI:10.1002/wps.20716

Why the field of moral philosophy must guide any discussion on well-being

Fava and Guidi[1] argue that "clinical attention to psychological well-being requires an integrative framework which may be subsumed under the concept of euthymia". We welcome the call for psychiatrists to take an integrative approach to well-being that researches, debates, and fosters "positive" well-being in addition to just focusing on distress. The challenge will be achieving this whilst keeping the profession relatively free of value judgements on how people ought to live their lives.

Regrettably, a millennium of philosophical work has failed to find a way to

operationalize positive and negative well-being without either assuming that a person's own subjective assessment of his/her life is valid, or prescribing a definition about what constitutes a person's well-being. Whatever way forward psychiatry chooses, it must be done with full awareness of what assumptions are being made and how viable those assumptions may be.

One of the worst mistakes in psychiatry's history was the identification of homosexuality as a disorder prior to changes in the 1980s. This arose from adopting value definitions of what constituted a normal, "good" life, as supported by the psychoanalytic theories of the time. Since then, psychiatry has strived not to adopt value assumptions in favor of identifying disorder based on observations of clusters of objective symptoms. To ensure that symptoms do not simply represent healthy individual differences, diagnosis must also show that these symptoms cause clinically significant distress or significant impairment in an important domain of the individual's life.

The extent to which psychiatry has been successful in correctly identifying disorders in a value free manner remains a focus of debate, but the work of the last decades has been an attempt to do so. Should the field choose to embrace a wider positive well-being framework (or even individual indicators of positive well-being), then value judgements have to be radically reintroduced. Disorders are currently justified based on clusters of observed symptoms, which is likely to be supplanted by a neuropsychiatric framework when technology allows the specification of disordered biological functioning. Adding anything to this model involves value laden questions regarding what should be added, why, and on whose opinion should the inclusion be based. In doing so, we must remain aware that homosexuality was pathologized on the basis of expert opinion and seemingly valid assumptions, supported by a rigorously developed psychological model. It would be hubris to assume that in our age, unlike any prior, we are now able to decide what constitutes good functioning. This problem applies irrespective of whether one wants to replace the DSM, add additional considerations, or situate that manual within a larger framework.

Philosophically, apart from the absence of disorder, well-being can be defined either subjectively by the person's own opinion, or normatively by the satisfaction of externally defined criteria. Within economics and politics, there has been a focus on using people's own satisfaction with their lives as a subjective measure of their well-being, most simply by asking, on a 0 to 10 scale, "all things considered, how satisfied are you with your life?". This measure has recently been adopted by the Organisation for Economic Co-operation and Development (OECD)[2] – an intergovernmental organization with 36 member countries – as a core measure of societal performance, health care intervention, and policy.

This measure *appears* fair and value free, in that everyone can be measured on the same scale, and people are free to base their answer on whatever parts of their life they value and in whatever way they want to evaluate them. However, A. Sen was awarded Nobel Prize in economics partially for criticisms of this subjective approach. Briefly, he highlighted that people living in poverty with ill-health may consider themselves very contented, simply because they are not aware of any alternative[3]. Indeed, they could score higher than a wealthy person in a well-provisioned society. Similarly, people indoctrinated into believing that they are in a good situation (through state propaganda or cult control) may rate themselves as more satisfied with their life than other people. Subjective evaluations of one's own well-being require information and cognitive abilities; as such, adopting this approach may be particularly problematic when evaluating psychiatric patients.

If well-being cannot be wholly defined by the absence of disorder, nor the individual's own subjective judgement of his/her life, then this leaves only the normative approach based on criteria developed by others. The quality of these accounts have ranged from characteristics based on researchers' own views to the virtue ethics approach beginning with Aristotle[4], which has been subjected to millennia of evaluation and refinement based on the philosophical method. This method (of which science is a special case) involves logically exploring inconsistencies and paradoxes, and seeking to falsify theory by logical counterarguments. These well-articulated and defensible virtue ethics of what should comprise a set of criteria for well-being are extensively discussed in textbooks for undergraduate philosophy courses.

However, despite contemporary measures commonly thought of as linked to virtue ethics[5], the model is complex, and there are no measures of virtue ethics criteria currently available. This confusion is a good example of why engagement with philosophers is essential in order to understand and articulate the nuances of theory. Of course, not all normative approaches are based on virtue ethics, such as the WHO-5 Well-Being Index[6]. This entirely positively worded questionnaire of happiness has been designed to measure individuals on five specific domains of life. Regardless, all normative accounts of well-being specify for others what happiness is, and thus epitomize the exact form of value judgements that psychiatry has aimed to purge.

We value Fava and Guidi's provocative contribution to furthering a psychiatry that includes positive well-being, and we have made similar calls ourselves within clinical psychology to which any criticism would equally apply[7,8]. We are heartened to see the publication of these radical ideas in a mainstream psychiatry journal and encouraged by the appearance of their paper as the target article to be printed alongside commentaries. This is a very important debate to have.

However, our key point is that the debate must take full consideration of the (often deeply buried and unintuitive) underlying assumptions that are inherent in any definition of well-being, irrespective of whether the account is based on the absence of disorder, subjective, or normative accounts. Further, such a debate must be informed by the discipline of philosophy.

Since inception, philosophy has had this very debate on what constitutes well-being (or the "good life") and how it should be practically used. As such, regarding the nature of well-being, only philosophy has developed the relevant epistemological

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.

Alex M. Wood, Adam T. Davidson
London School of Economics and Political Science, London, UK

1. Fava GA, Guidi J. World Psychiatry 2020;19:40-50.
2. Organisation for Economic Co-operation and Development (OECD). How's life?: measuring well-being. Paris: OECD, 2011.
3. Sen A. Oxford Econom Pap 1983;35:153-69.
4. Aristotle (translated by Ross WD, Brown L). The Nicomachean ethics. Oxford: Oxford University Press, 2009.
5. Ryff CD. Psychother Psychosom 2014;83:10-28.
6. World Health Organization (WHO). Wellbeing measures in primary health care/The Depcare project. Copenhagen: WHO Regional Office for Europe, 1998.
7. Wood AM, Tarrier N. Clin Psychol Rev 2010;30:819-29.
8. Johnson J, Wood AM. Cogn Ther Res 2017;41:335-49.

DOI:10.1002/wps.20717

Euthymic suffering and wisdom psychology

In Fava and Guidi's paper[1], 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[2]. 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[3]. 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[4]. 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[5]. "Regeneration therapy"[6] 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"[7] teaches the art of enjoyment and experiencing of pleasures. "Well-being therapy"[1] 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[8]. 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"[9]. 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),