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## Can mental health services help people to flourish?

By Kenneth Gordon

As a Clinical Psychologist, I have spent most of my career working in a field where the aim is to reduce the suffering of people who are experiencing some form of mental disturbance. Psychologists usually work on an individual basis, looking at what a person has learned from their life experiences, and how that may be creating or maintaining their current emotional and other problems. This hypothesis about the cause of their difficulties is known as a case formulation, and should help us identify ways to try to break the pattern.

However, the dominant model in the field remains medical and is based on diagnosis rather than formulation. In this (psychiatric) view, we can define a range of common disorders, each with a typical pattern of symptoms. With any individual, the task is to diagnose their condition accurately so as to offer a treatment designed for that disorder. It is an unspoken assumption within a medical approach that, once illness has been successfully treated, the person should be able to spontaneously resume a productive and happy life. But is that true?

The newer field of Positive Psychology has, by contrast, focused on the general population with the goal of helping people to lead rewarding and meaningful lives. Terms like mental health, well-being and flourishing are variously used to describe this optimum state of functioning, and there is some evidence that we can move people towards it (Sin and Lyubomirsky, 2009). A more recent meta-analytic study by Bolger et al., (2013) assessed 39 well-designed studies of the effects of positive psychology interventions on subjective well-being (i.e. positive mood), psychological well-being (mastery and effectiveness) and depression, and found a consistent, albeit relatively modest impact.

In this setting, governments have begun to see well-being as a target for society which is as important as economic success. Some proponents of this approach believe that, if flourishing can become the norm, then we will reduce the incidence of mental illness in our society (Foresight, 2008). Again we have to ask, is that realistic?

In this article, I will address these questions by looking at the relationship between the concepts of mental illness and mental health, suggesting

that they need to be considered in slightly different ways. I will go on to explore some new and interesting work on the boundary of the two areas, and how this suggests ways to promote more complete mental health and well-being.

## Mental health and mental illness

At first sight, mental health and mental illness seem like opposites on a single continuum, where one can move progressively from severe illness to milder disturbance, then on to moderate mental health, and finally reach an optimum state of flourishing. This presumption underlies most work to date. For example, Huppert and So (2013) say that well-being 'lies at the opposite end of a spectrum to the common mental health disorders (depression and anxiety) (p.837). However, the relationship is more complex than that.

As a clinician, I can point to people who do not meet the criteria for any formal psychiatric diagnosis, yet lead lives of chronic unhappiness and dissatisfaction. Equally, I have known people with symptoms of severe conditions such as schizophrenia, who nevertheless function well in most areas of life, have strong relationships, and seem contented. This does not sit easily with the single continuum model. Instead, Corey Keyes (Keyes 2005, 2007; Keyes and Lopez 2002) has argued that mental illness and mental health form two related but separate dimensions. After analysis of very large scale survey data, he concluded that people may be best categorised as being with or without mental illness, and at three levels of mental health, which he labelled flourishing, moderate mental health, or languishing. My first example above would, in his terms, be 'languishing' but without any mental illness. The second would be experiencing mental illness, yet still have moderate levels of mental health.

One implication of this two-dimensional view is that effective treatment of mental disorders can never, on its own, result in complete mental health. To see the sense of this, we only have to look at the example used by Hayes et al. (1999) to critique what they call the 'assumption of healthy normality'. They point out the shockingly high prevalence of suicidal thinking, which appears to occur for a significant period of time in as much as half the general population. Clearly, not all these people can have a mental illness, but they are certainly not flourishing.

The other implication is that strategies designed to improve well-being will never be an adequate replacement for therapies which directly target mental disorders. This was highlighted in the recent Annual Report of the Chief Medical Officer for England, Professor Dame Sally Davies (Davies, 2014). In forthright language, she stated 'I conclude that well-being does not have a sufficiently robust evidence-base commensurate with the level of attention it currently receives in public mental health at a national and local government level' and 'Contrary to popular belief, there is no good evidence I can find that well-being interventions are effective in primary prevention of mental illness' (Chapter 1, p.14).

In summary, as Keyes says, 'Mental health is therefore best viewed as a complete state, i.e. not merely the absence of mental illness but also the presence of mental health' (Westerhof and Keyes, 2010). This statement echoes The World Health Organization's overview of health as 'A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 2004). A genuine mental health approach might therefore be one which not only treats problems but also enhances flourishing (Slade, 2010).

## Clinical versus Positive Psychology

That combination remains rare to date. The methods of clinical and of positive psychology may have always had a few common elements, but these have been used to work for very different goals. For example, clinicians might use Cognitive Behavioural Therapy (CBT) methods such as identifying and testing thoughts to reduce the negative thinking that supports depression, while life coaches adopted those same methods to instil optimism and positivity. CBT also proposes activation for depressed clients, encouraging them to gradually resume or increase daily activities which create a sense of pleasure or mastery, so as to combat low mood. Positive psychology focuses on activity too, but frames it as a step towards a life of engagement and meaning.

We should not be thinking of these as either/or approaches in two separate fields. Rather, in taking Keyes' two dimensional approach, we might think of two stages of work, the first to resolve any mental health problems, the second to foster positive well-being. In the past, clinicians conceptualised these two stages as treatment, which could, if successful, be followed by rehabilitation and relapse-prevention. This is a clear example of the medical model in action. Working from a psychological perspective, the stages become better integrated. The first seeks to modify unhelpful beliefs and behaviour patterns which may have formed for good reasons but are now 'past their sell-by date'. The second takes this forward to encourage new patterns which will sustain growth and life change.

As an example, a young person who has been through traumatic or abusive experiences may be self-blaming, emotionally labile, and unable to trust others. This could lead to serious eventual consequences, ranging from academic underachievement to substance misuse and self-harm. While their past experience is fixed, their understanding of it, and the ways they compensate for it are open to change through therapy. For example, they might become more flexible in their judgements of themselves and others. Once achieved, this flexibility may allow them to risk taking opportunities for new experiences. In turn, if the process is managed well, this will bring new learning, more positive mood and more productive and fulfilling activities. These are the core ingredients of well-being.

## Therapies which target well-being

A few examples may give a flavour of current clinical work which contributes to the goal of complete mental health rather than only 'treatment'. This has been a particular characteristic of the so-called 'third wave therapies' which introduced a different style of CBT, which has now become part of the mainstream approach in mental health. Typically in this style of work, mindfulness meditation is used to alter people's perspective on their problematic thoughts and emotions. To illustrate this, imagine I was struggling with a difficult task and found myself thinking 'I can't do this, I'm useless'. This automatic thought might, in that moment, seem like an accurate summary of the situation and of my value, and I might feel upset as a result. In traditional CBT, the thought and the ensuing distress would be treated as problematic. I might be asked to challenge the evidence that the thought was true and then look for less negative ways to interpret the situation, with the therapist prompting me by asking, 'Have you succeeded with similar tasks before?' or 'Are you effective with any other things you do?'. By contrast, the mindfulness approach would simply encourage me to notice my thought, and then let it go by, as if it were nothing more than background noise. My focus would remain on achieving the original task. The goal is therefore to achieve a fuller engagement in my valued aspects of life, rather than becoming bogged down in a circular battle with internal thoughts and emotions. This is typified by Steve Hayes' Acceptance and Commitment Therapy (ACT) (Hayes et al., 1999), which seeks to 'Create a rich and meaningful life, accepting the pain that inevitably goes with it'.

In a similar vein, Marsha Linehan's Dialectical Behaviour Therapy (DBT) (Linehan, 1993) sets the explicit goal of 'a life worth living' for people who were previously suicidal, and teaches skills for more effective living alongside mindfulness and the modulation of emotions.

Ruini and Fava (2012) more recently described a method which they explicitly call 'Well-being therapy'. It was developed to help in long-lasting conditions such as generalised anxiety disorder but has much wider relevance, as it targets greater flourishing and resilience. It does so by using an adaptation of educational and CBT methods to work in six areas: autonomy, environmental mastery, personal growth, purpose in life, self-acceptance and positive interpersonal relationships. For example, people are asked to keep a diary of experiences of well-being. As well as drawing attention to these moments, they are also helped to identify and challenge any thoughts which may obstruct or interrupt the positive feeling.

Strengths-based CBT (Padesky and Mooney, 2012) has a related aim of building resilience, which the authors see as a key element of well-being, allowing us to bounce back in the face of life's obstacles. It is as relevant to daily life as to the recovery from illness. They suggest it can be fostered in a four-step process. Initially, they work on (1) exploring personal strengths and (2) using these strengths to construct new strategies for

resilience. The process is made relevant and vivid by drawing imagery and metaphors from the client. For example, a keen weekend footballer might be encouraged to plan strategies for dealing with criticism at work using the idea and visual image of 'getting back up from the tackle'. In the remaining stages, they work on bringing these strategies into everyday life via (3) applying them to plans, with a focus on showing resilience rather than achieving an outcome, and (4) carrying out and reviewing 'experiments' to test and refine the new skills.

Bannink (2012) has described another adaptation of existing methods called 'Positive CBT', where she says 'Clients and therapists are invited to shift their attention from analysis, explanations, and problems, to thoughts, actions and feelings that can help clients flourish'. Her book emphasises the use of strengths, positive emotions and a focus on solutions.

## Looking ahead

Through these and other clinically based approaches, we are beginning to offer powerful ways to foster subjective well-being (i.e. positive emotions and satisfaction) alongside psychological well-being (the sense of purpose and growth). Arguably, we are bringing positive psychology into the clinical arena. Our 'case formulation' can now be as much about fostering strengths as addressing needs and perhaps, mental health services can finally live up to their name and encourage Keyes' notion of complete mental health.

Of course, developments of this sort have to be shown to be useful. We will need to measure more than symptom reduction and seek to prove that targeting well-being has a worthwhile impact on people's quality of life after (or alongside) serious illness. At present, mental health services tend to measure symptoms and sometimes life satisfaction, while often missing the intervening variables like self-esteem, life skills, positive emotion and a sense of purpose. Unfortunately, with at least four separate approaches to the definition of well-being (Joseph & Wood, 2012; Hone et al., 2014) we still have some way to go before achieving consensus on what exactly needs to be measured in the future. This will be a prerequisite for better mental health services which really do allow people to flourish.

## Author

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