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Chris Peterson’s unfinished masterwork: The real mental illnesses

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The theory of strengths also implies a theory of disorder that proceeds from knowing what is right in a person: pathology is the opposite, or the absence, or the excess of the strengths. Chris Peterson left a table that details this theory. I discuss the relation of the pathologies so derived to Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) disorders and I speculate on its treatment implications. If fleshed out, I suggest it is a viable alternative to DSM.

Keywords: mental health; character strengths

Chris Peterson had two major strengths that do not appear in the Character Strengths and Virtues (Peterson & Seligman, 2004), because they are local and not universal. The first was ‘getting it out the door,’ turning an idea into an article or a book and doing so without shilly-shallying. The second was doing what he said he would do, usually doing more. For years, I urged Chris to get this one done, and he said he would do it, but he kept putting it off. Some questions are just too hard for me, and the fact that he did not finish it meant that this one must have been too hard even for Chris’s capacious intellect.

My thoughts on this issue just scratch the surface, but I present it in this memorial issue in the hopes that one of my readers will deepen it and finish it. I just know Chris would have wanted this too.

The basic idea has two parts. The first part is a simple one: that Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) 3 through DSM 5 do not identify the ‘real’ mental disorders. The second would have been Chris’s masterwork: that the 24 strengths of Peterson and Seligman (2004) do.

The Diagnostic and Statistical Manuals of the American Psychiatric Association (1980, 2000, 2013) in their third through fifth editions are intentionally and explicitly not a theory of mental illness. This was an about-face from DSM-1 and 2 (1952, 1968) which were Freudian theories of mental illness, with underlying anxiety at the heart of many of the disorders. The fundamental tactic in DSM-3 was to get diagnostic agreement across locations, so each of the pathologies consists merely of a list of symptoms. For a patient to be diagnosed with a specific disorder, some number of the symptoms must be present for some length of time in order to qualify. So for example, five of the following nine symptoms must be present for two weeks or more for major depressive disorder to be diagnosed (DSM-4; 2000):

- Depressed mood.
- Markedly diminished interest or pleasure in all, or almost all, activities.
- Significant weight loss or decrease or increase in appetite.
- Insomnia.
- Psychomotor retardation or agitation.
- Fatigue or loss of energy.
- Feelings of worthlessness.
- Diminished ability to think or concentrate, or indecisiveness.
- Recurrent thoughts of death or recurrent suicidal ideation.

While diagnosis by symptoms is a virtue for diagnostic reliability and for replicable research, it is not a virtue for the understanding of mental illness. Before the nineteenth century, the diagnosis of smallpox was by symptoms: small poxes on the face and body, fever, and death. Due to the work of Edward Jenner on immunization in the nineteenth century, a germ theory of smallpox was articulated and confirmed, and the presence of the variola virus became the necessary condition for the correct diagnosis. Some of the cases that had the cluster of symptoms proved not to be smallpox, and others that did not show the hallmark symptoms proved to be smallpox. This was a truly major theoretical advance in the understanding of smallpox.

DSM’s categories consist, so Chris and I thought, of mere congeries of symptoms. The modern DSM’s rejecting the Freudian theory of mental illnesses threw the baby out with the bathwater. What was missing was an

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underlying theory of the mental illnesses, but with something more scientifically workable than the Freudian theory.

Chris believed that he had discovered such a theory, a theory which emerged from Character Strengths and Virtues (Peterson & Seligman, 2004). I should note that I barely deserved second authorship of this book. Chris did all the hard work; I merely got the funding and then cheered him on. In this book, we presented a theory of ‘what is good in a human being.’ What is good were called ‘strengths,’ and such a strength had to meet these criteria (among others):

(1) A strength contributes to fulfillment and to the good life.
(2) A strength is morally valued in its own right.
(3) Displaying a strength does not diminish others.
(4) Almost every parent wants their child to have the strengths.
(5) There are rituals and institutions within a society that support the strength.
(6) Each of the strengths is universal, valued by almost every religion, politics, and culture – now and in the past.

Another criterion is that there exist people who are profoundly deficient in each particular strength, and it was from this criterion that Chris’s insight into mental illness emerged. His theory of mental illness proceeds from first knowing what is right in a person, before one can know what is wrong in a person. He bequeathed to us a table that is the skeleton of the theory. Here is the Table 1. Please study it carefully since it is the very heart of this brief article.

The theory is Aristotelian, evoking the health of the golden mean: it claims that psychological health is the presence of the strengths and that the real disorders are the absence, the excess, or the opposite of the strengths. Since there are 24 strengths, that generates 72 (3 × 24) pathologies, and Chris did his best at a first approximation of what each might be called.

Some of his labels seem right. For example, the strength of Forgiveness: its opposite is vengefulness, its absence is mercilessness, and its excess is over-permissiveness (‘whatever,’ a word that Chris used often with tongue-in-cheek disapproval of American youth). The strength of Kindness also works: its opposite is cruelty, its absence is indifference, and its excess is over-intrusiveness. For Hope, its opposite is despair, its absence is present-mindedness, and its excess is over-optimism.

Other labels need more work: For Bravery, its opposite is cowardice, and many of the DSM ‘anxiety’ disorders exemplify cowardice, although overly kind therapists never use this word. Its excess, foolhardiness, also seems right. But its absence is not really captured by ‘fright.’ For fairness, its opposite, prejudice, seems right, but its absence does not seem to be quite ‘partisanship,’ and its excess is not ‘detachment.’

So one very demanding task will be filling out of the table.

The second task is spelling out how the 72 ‘Peterson’ pathologies relate to the DSM disorders. The Peterson pathologies are related to some DSM disorders, but they do not subsume them, neither does Peterson map into DSM nor DSM. In other words, the Peterson theory is decidedly not an attempt to reconstruct the DSM disorders.

Some of the DSM categories are related to the Peterson pathologies: ‘Despair,’ the opposite of hope, captures a big piece of Major Depressive disorder. But it does not capture all of Major Depressive Disorder. It does not, for example, require that sadness occur almost every day, as does DSM. At this juncture, Despair is not operationalized, so it does not require five of the nine DSM symptoms. Despair, in other words, does not subsume Major Depressive Disorder, nor does it aim to.

The DSM disorders do not all map into the Peterson disorders: DSM ‘Panic Disorder’ and ‘Generalized Anxiety Disorder’ are not to be found in the Peterson table, although ‘cowardice’ is related to both – but cowardice does not distinguish the two.

The Peterson disorders do not all map into DSM disorders: ‘Orthodoxy,’ the opposite of ‘Love of Learning’ is certainly not an Axis-1 DSM disorder, although it might be related to some of the Axis-2 Personality disorders of DSM-4 (no longer to be found in DSM-5). Humorlessness, the absence of humor, is nowhere to be found in DSM, except as an accessory symptom of depression – the loss of mirth.

So it would be a mistake to ask for a mapping of DSM into Peterson and from Peterson into DSM. This is not what Peterson set out to achieve. Rather his theory starts with the definition of strength – what every culture values as the ‘good’ in a person, what every parent wants for their children – and asks systematically in what direction these can go awry. While Peterson’s theory does not tell us how these develop (since causation is a matter of empirical discovery, not of theory), not having the strengths are the real mental illnesses. In its strongest form, the theory claims that the three ‘awrynesses’ of the 24 strengths are the basis of an exhaustive and exclusive categorization of mental illness. So on this account, bipolar depression is decidedly not a mental illness, although some of its symptoms – recklessness and grandiosity – are. Schizophrenia is not a mental illness, although some of its symptoms – anhedonia is related to ‘lifelessness’ and cognitive distortions are related to ‘foolishness’ – are.

If we were beginning all over again, how would we choose between the idea of DSM and the idea of the
PTSD. Anxiety and depression are enormously
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Peterson scheme? It might be argued that one superiority
of DSM over Peterson is that the symptoms of the DSM
mental illnesses cluster together well and so form ‘syn-
dromes.’ This is just not true. One of the perennial
objections to the DSM’s is the notoriously low specifici-
ty of the symptoms: cognitive distortions, for example
occur in schizophrenia, depression, phobias, OCD, and
PTSD. Anxiety and depression are enormously ‘co-mor-
bid’ for symptoms. High ‘co-morbidity’ and the fact that
the diagnosis is usually of the five-out-of-nine variety is
the clue to looseness of the ‘ syndromes.’ The Peterson
mental disorders, in contrast, tend to be purer categories,
more uni-dimensional and hence less subject to the,
‘congeries of symptoms’ swamp. Do keep in mind, how-
ever, that if and when the Peterson categories are
systematically operationalized into diagnostic form, they
too will have ‘symptoms’ which likely, but not certainly,
will inter-correlate well: So what are the ‘ signs or
symptoms’ of ‘boredom?’ Listlessness, fidgeting, hyper-
somnia, and meaninglessness? And how do they
inter-correlate? And do they also occur in ‘despair?’

Peterson categories have advantages over DSM cate-
gories in that

1. They are theory based, systematically related to
each other; they are not a laundry list of disorders.
2. They are defined by universality and so lend
themselves to cross-cultural psychopathology.
3. They are purer, natural classes.
4. They are not tied to a medical model, demanding
symptoms, syndrome, and illness.
5. They are not reductionist and do not demand a
biological basis as the ultimate criterion of com-
pleteness.

What are the treatment implications of the Peterson
disorders? DSM did not set out to be a treatment manual.
Rather it was only supposed to be a guide to research that
would standardize diagnostic disagreement across the
world, allowing replicable research. But it got out of hand
through an economic accident. DSM-3’s publication coin-
cided with the rise of reimbursement for treatment by
insurance companies and the United States government,
and so, lacking anything else, it became the basis for
reimbursing treatments – even if treatments for the cate-
gories were not evidence based. The principal granting
agency, NIMH, fell into line right away, funding research
largely on DSM categories. Because reimbursement was
prematurely tied to treating the DSM categories, drugs,
and psychotherapies appeared that were tailored to treat
the categories – as opposed to treating the underlying
biology or the underlying cognitive or emotional basis
(Forgeard et al., 2012). The psychological basis and the
biological basis turn out to be nonspecific, however, only
loosely tied to the categories. So, for example automatic
thoughts occur not only in depression, but in phobias,
obsessive-compulsive disorder, and PTSD, and serotonin
deficits, originally thought to be specific to depression,
occur in a wide range of other psychopathologies.

So we are left with a treatment potpourri: biological
and psychological treatments were gerrymandered into
the DSM categories for the sake of reimbursement. The

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treatments when they work are not specific, for example antidepressant drugs work about as well (marginally, that is) on anxiety and in bulimia as they do on depression. When they do work, they rarely exceed 65% efficaciousness against very substantial placebo effects (Seligman, 2011). Trials on the medications are rarely extended beyond six weeks and very worrisome long-term effects are increasingly appearing (Whitaker, 2010). Add to this, the sad fact that the $30 billion, 30-year investment in neuroscience and the equally expensive human genome project have resulted so far in no new therapeutics and that neither the neuroscience discoveries nor the genetics discoveries map into the DSM categories, e.g. no discrete genetics of major depression has been isolated, and no neurotransmitter properties correlate more than marginally with major depression.

These problems have led to an important development in the classification of mental disorders: the Research Domain Criteria (RDoC) initiative of the National Institute of Mental Health. http://www.nimh.nih.gov/research-priorities/rdoc/nimh-research-domain-criteria-rdoc.shtml This endeavor seeks to identify converging patterns across genetic, neural, behavioral, and self-report systems. Systematic converging deficits, if discovered, would become criteria of disorders. So, for example loss might show a converging pattern of neural, genetic, cellular, and self-reported despair. Such a pattern would then be the criteria of a ‘loss disorder.’ These newly discovered disorders might or might not map onto DSM disorders. I support such an endeavor; promissory and covered disorders might or might not map onto DSM categories, e.g. no discrete genetics of major depression has been isolated, and no neurotransmitter properties correlate more than marginally with major depression.

In conclusion, Chris Peterson left a great project undone, but he bequeathed us a theory and a table to work from. His theory suggested that while the 24 strengths are the ‘good’ in a person, their absence, their opposite, and their excess are the ‘ill’ in a person. Given the difficulties facing DSM 5, it is my hope that Chris’s scheme will be taken seriously.

Finally, are the Peterson pathologies treatable?

The real answer, of course, is that we don’t know, since the question has not been asked previously. But there are a few spotty clues:

- Cowardice can be ameliorated by systematic desensitization.
- Despair can be ameliorated by cognitive therapy.
- Helplessness can be relieved by mastery training.
- Loneliness can be relieved by anti-shyness training.

References