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Positive Psychiatry, Neuroscience, End of Life, and Other Essays

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Bioethical and Other Philosophical Considerations in Positive Psychiatry

Ajai R. Singh* and Shakuntala A. Singh**

ABSTRACT

The paper begins by asserting the need for bioethical and related philosophical considerations in the emerging subspecialty Positive Psychiatry. Further discussion proceeds after offering operational definitions of the concepts fundamental to the field – Bioethics, Positive Psychology, Positive Psychiatry and Positive Mental Health - with their conceptual analysis to show their areas of connect and disconnect. It then studies the implications of positive and negative findings in the field, and presents the Positive Psychosocial Factors (PPSFs) like Resilience, Optimism, Personal Mastery, Wisdom, Religion/Spirituality, Social relationships and support, Engagement in pleasant events etc. It then evaluates them on the basis of the 4-principled bioethical model of Beneficence, Non-malfeasance, Autonomy and Justice (Beauchamp and Childress, 2009[5], 2013[6]), first offering a brief clarification of these principles and then their bioethical analysis based on the concepts of 'Common Morality', 'Specific Morality', 'Specification', 'Balancing' and 'Double Effects'. The paper then looks into the further development of the branch by studying the connectivity, synergy and possible antagonism of the various Positive Psychosocial Factors, and presents technical terms in place of common terms so that they carry least baggage. It also takes note of the salient points of caution and alarm that many incisive analysts have presented about further development in the related field of Positive Mental Health. Finally, the paper looks at where, and how,

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the field is headed, and why, if at all, it is proper it is headed there, based on Aristotle's concept of the four causes - Material, Efficient, Formal and Final. Suitable case vignettes are presented all through the write-up to clarify concepts.

Key Words: *Aristotle's four causes - Material, Efficient, Formal and Final; Autonomy; Balancing; Beneficence; Bioethics; Common morality; Double-effects; Ethics; Justice; Morality; Non-malfeasance; Optimism; Particular morality; Personal mastery; Positive Mental Health; Positive Psychology; Positive Psychosocial Factors; Principlism; Pseudo-optimism; Pseudo-resilience; Resilience; Social engagement; Specification; Spirituality/Religiosity; Wisdom*

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Introduction

1. The need for ethics in psychiatry

Traditionally, there is little grounding in ethics that psychiatrists undergo, either in their education or training. So they maybe pardoned if they are often blind to the ethical implications of their clinical actions. Some may harbour the notion that being in an objective, scientific discipline, they are unaffected by values, since science is essentially value-neutral. Also, there maybe the unexpressed concern that being preoccupied by ethical implications of their procedures may paralyze them from necessary action, both in therapy and research.

All these situations and thinking patterns are much in need of repair. Reasonable amount of work has been done in this direction, notably by Fulford (2008[20]), the *Oxford Handbook of Philosophy and Psychiatry* (Fulford *et al*., 2013[21]) and Bloch and Chodoff, 1984[10]. We have also added our bit (Singh and Singh, 1989[72], Singh and Singh, 2009[74]) with one of us writing a chapter on the bioethics of Positive Psychiatry (Singh 2015[71]).

To aid in the grounding in ethics that psychiatrists' lack, this paper will be a step, so they no longer remain blind to the ethical implications of at least this nascent branch of psychiatry. And although *pure* science is essentially value-neutral, *applied* science is not, as also its procedures and interventions. This is because they are very much concerned with human beings and society, and anything so concerned cannot remain value-neutral. Psychiatry (including Positive Psychiatry, which is the subject of focus here) falls in the category of applied sciences, not pure sciences. Hence, it needs to be very much concerned with the right and wrong of its procedures and treatments, i.e. their ethical implications.

Further, although preoccupation with ethical implications can paralyze much needed actions, it is only *preoccupation* that can do so. A healthy understanding of the ethical implications of actions can provide that much needed justification and forward thrust for legitimate action, even whilst pre-empting known, and often unknown, malafide action.

It makes eminent sense, therefore, to look into the bioethical and other related philosophical implications of Psychiatry in general, and of Positive Psychiatry in particular, since that is the focus of consideration here.

There is also the need for collaborative effort between psychiatrists and bioethicists. Bioethicists can tease out the philosophical notions of healthcare values and preferences, while psychiatrists can tease out the clinical and pharmacologic variables (Schneider and Bramstedt, 2006[66]). A psychiatrist-bioethicist would be very suited to integrate efforts in this direction.

2. Should there be a Chapter on Bioethics in a Book of Positive Psychiatry?

For that we have to first answer the fundamental question: what is the essential justification for the role of bioethics in psychiatry? It is that the problems facing psychiatry today are shaped by the emergence of dilemmas created by science and technology but not solvable by them (Lolas, 2002[50]). For example, issues like covert medication, involuntary hospitalization, informed consent, confidentiality in psychotherapy, electroconvulsive therapy, psychosurgery, and neuroethics. A lot of these dilemmas relate to health care values and preferences, where only the skill sets that bioethics provides can sort out issues.

This is as applicable to psychiatry as the whole of medicine. In medicine, take for example, an issue like stem cells or embryo research, which 'has become a hot-button political issue involving scientists, policy makers, politicians and religious groups' (Al-Rodhan, 2015[1]). Or, for that matter, cloning, brain like computer chips and smart pharmacology. Come to think of it, it is equally applicable to all science and technology. Take, for example, genetically modified organisms (GMOs), discussions on which 'have mobilized civil society, scientists and policy makers in a wide debate on ethics and safety. The developments in genome-editing technologies are just one example that bioresearch and its impact on market goods are strongly dependent on social acceptance and cannot escape public debates of regulation and ethics' (Al-Rodhan, 2015[1]). The John J. Reilly Center for Science, Technology, and Values at the University of Notre Dame has released an annual list of emerging ethical dilemmas for science and technology for 2015 which include issues like Brain-to-brain interfaces, Real-time satellite surveillance video, Resilient social-ecological systems, Artificial life forms, Robot swarms, Non-lethal weapons, Enhanced pathogens, State-sponsored hacktivism and 'soft war', Wearable technology and Astronaut bioethics (of colonizing Mars) (Baron, 2014[3]).

Indeed, bioethical implications are a concern in *all* endeavours that impact human life. The dilemmas related to such activities are created by them but not solvable by them. Here only the skill sets of bioethics can offer pointers.

The same cannot but be applicable to Positive Psychiatry.

It should now be easy to answer the question: why the bioethics of Positive Psychiatry. It is because the problems facing the nascent field today, and in the future, will be shaped by emergence of dilemmas created by related science and technology but not solvable by them. A lot of them will relate to health care issues and preferences, where the skill sets that bioethics can provide will help sort issues out.

Hence, a chapter on the Bioethics of Positive Psychiatry in a book on Positive Psychiatry is legitimate (see, for example, chapter by Singh, 2015[71]). In fact, a chapter on bioethics is legitimate in *every* textbook of *every* branch of medicine, including psychiatry. Come to think of it, a chapter on ethical implications is legitimate in *every* worthwhile textbook of *every* branch of science and technology. Sidestepping, or ignoring them, is mainly responsible for the hassles scientific branches develop when they come in conflict with social norms and values.

We will have occasion to look at some of these problems in relation to Positive Psychiatry in this paper, and apply the skill sets that bioethics provides to solve them. Future work should hopefully throw more light on further developments and related ethical health care dilemmas in the field.

3. How do we go about it in this paper?

We shall first lay the groundwork for further discussion by offering operational definitions of the concepts fundamental to the field – those of Bioethics, Positive Psychology, Positive Psychiatry and Positive Mental Health. We will carry out their conceptual analysis to show their areas of connect and disconnect. We will then study the implications of positive and negative findings in the field, and evaluate them on the basis of the 4-principled bioethical model of Beneficence, Non-malfeasance, Autonomy and Justice (Beauchamp and Childress, 2013[6]), first offering a brief clarification of these principles and then their bioethical analysis. The related concepts of 'Common morality', 'Specific morality', 'Specification', 'Balancing' and 'Double effects' and how they are connected to Positive Psychosocial Factors and Principlism will then be analysed. We will then look into the further development of the branch by studying the connectivity, synergy and possible antagonism of the various positive psychosocial factors, as well as enquire whether there is need for the use of technical terms with least baggage. We will also take note of the salient points of caution and alarm that many incisive analysts have presented about further development in the related field of Positive Mental Health. Finally, we will look at where, and how, the field

is headed, and why, if at all, it is proper it is headed there, based on Aristotle's well acclaimed concept of the 4 causes - Material, Efficient, Formal and Final.

4. Simplifying concepts and case vignettes

All along, the concepts dealt with will be explained in simpler terms for the uninitiated, so that difficult appearing philosophical concepts can be understood and appreciated by most, and especially those who steer the field, or are its opinion makers.

Traditionally, the philosopher has been used to a language 'so abstruse as to intimidate even the most eager psychiatrist' (Bloch and Chodoff 1984; p7[10]). That makes many psychiatrists, and other medical scientists, remain oblivious to what philosophers, and bioethicists, have to say about their respective branches. This is so not because they don't value it, but often because they simply don't understand the subtleties and nuances of the philosophers' arguments because of the language they use. If this happens with those whose opinion matters, it hurts the long-term purposeful growth of the branch. So, we will temper the philosopher's 'absolutism' with the psychiatrists' 'utilitarianism' (Singh and Singh, 1989[72]). How? By adding suitable case vignettes from time to time in the write-up. This, we believe, will aid the process of better understanding and clarity of these 'difficult looking' concepts.

Operational definitions

Before we proceed ahead, it may be fit to offer operational definitions of the four concepts we are to cover in this paper: Bioethics, Positive Psychiatry, Positive Psychology and Positive Mental Health.

1. Bioethics

Bioethics is a branch of practical ethics in the field of philosophy of biology/medicine, which deals with the propriety/impropriety of procedures and issues connected with biology and medicine. By *procedures* we mean interventions e.g. abortion, euthanasia, surrogacy, organ transplantation, cloning, gene therapy, human genetic engineering etc. By *issues* we mean entities like suicide, patients' rights, advocacy, health care rationing, life extension arguments etc.

Those who deal with issues like these are termed bio-ethicists. They typically apply the principles of pure and applied ethics, both absolutist (also called deontological; including Kantianism and Kant's Categorical Imperative, see Kant 1785/1968[39]) and utilitarian, to analyse and critique these, and related, phenomena.

The four fundamental principles that guide and influence bioethicists on a wide range of issues are Beneficence, Autonomy, Justice (Belmont Report,

1979[8]; Beauchamp and Childress, 2013[6]), and Non-malfeasance (Beauchamp and Childress, 2013[6]). They are also useful conscience keepers for medicine in general, and biomedical ethics and psychiatry in particular. But they need (1) the utilitarians' detailed blueprinting; (2) the clinician's practical implementation; (3) the scientists'/researchers' hard-nosed verification; coupled with (4) the activists' constant surveillance (and, of course, a well-primed legal system to deal with transgressions, real or perceived) (Singh and Singh, 2009[74]). We shall have occasion to discuss most of these aspects of Positive Psychiatry later.

Biomedical ethicists are justifiably concerned with caution sounding and ringing alarm bells, which scientists intimately connected with advancement in their respective fields may not do themselves, or consider irritating impediments in their forward march. In caution sounding, bioethicists serve an important purpose by restoring much needed balance, and stemming unbridled growth. However, if bioethicists indulge in caution sounding alone, they do disservice to their enterprise, concerned as ethics is with both *right* and wrong, *good* and bad, *proper* and improper. In our bioethical discussion, we shall strive to maintain that balance.

2. Positive Psychiatry

Positive Psychiatry means the use of those measures and identifying those positive psychosocial attributes and processes (let's call them 'factors' from here onwards) that positively impact the prevention, treatment, rehabilitation and relapse of patients with medical diseases in general and psychiatric disorders in particular. Jeste and Palmer (2015[37]) give a useful similar operational definition of Positive Psychiatry as 'the science and practice of psychiatry that seeks to understand and promote well-being through assessments and interventions aimed at enhancing PPSFs (positive psychosocial factors) among people who have or are at high risk for developing mental or physical illnesses.' Its primary aim parallels that of Positive Psychology, with some important differences, both of which are discussed separately a little later.

What are these Positive Psychosocial Factors? There is no definitive list as yet, and the list is likely to expand as this is an emerging branch; but some of these include positive mental health outcomes (such as well-being, recovery, lowered perceived stress, successful psychosocial aging, and post-traumatic growth), as well as positive psychosocial factors that may contribute to these positive outcomes. Examples of such positive psychosocial factors include intrapersonal characteristics or 'traits' (such as resilience, optimism, personal mastery and coping self-efficacy, social engagement, spirituality/religiosity, compassion and wisdom), and positive environmental factors (such as family dynamics and social support).

3. Bioethics of Positive Psychiatry

Bioethics of Positive Psychiatry is concerned with, among other things, the issues of Beneficence, Non-malfeasance, Autonomy and Justice, as connected

with the development and implementation of procedures in Positive Psychiatry e.g. of positive psychosocial factors, including positive mental health outcomes, intrapersonal characteristics or 'traits' and positive environmental factors. It is also concerned with the concepts of 'common morality', 'specific morality', 'specification', 'balancing' and 'double effects' as connected to these procedures.

4. Positive Psychology

Positive Psychology has crystallized the wish and work of many who worked before its inception, but its origin is popularly accredited to the Presidential Address of Martin Seligman to the American Psychological Association in 1998, wherein he called for a paradigm shift from a focus on psychopathology to positive psychological health (Seligman, 1999[68]). The call was for a psychology of positive human functioning, which achieves scientific understanding and effective interventions to build thriving individuals, families, and communities (Seligman and Csikszentmihalyi, 2000[70]). It aims to 'catalyze a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities' (Seligman and Csikszentmihalyi 2000; p. 6[70]). Rather than merely treating psychiatric disorders, Positive psychologists seek to make normal life more fulfilling, and to find and nurture genius and talent (Compton, 2014[15]).

A useful operational definition of Positive Psychology would be the following: Positive Psychology is primarily concerned with using the psychological theory, research and intervention techniques to understand the positive, adaptive, creative and emotionally fulfilling aspects of human behaviour (Seligman, 2006[69]).

It is to be noted, however, that even though the emphasis and thrust offered by Positive Psychology to the study of positive emotions and behaviour is relatively new, the ideas, theories, research, and motivation to study the positive side of human behaviour is as old as humanity (Compton and Hoffman, 2012[16]).

5. How are Positive Psychiatry and Positive Psychology connected and disconnected?

Positive Psychology is concordant with Positive Psychiatry in that it studies and lists many psychosocial factors that make for positive living in both patients and non-patients. This it does by experimental study and presenting quantitative data, which also are the methods of Positive Psychiatry.

It is discordant in that, whereas Positive Psychology studies the personal and social attributes of those who live with well-being by following the positive determinants of health, Positive Psychiatry studies the personal and social attributes of those who either do not develop, or if they do, develop lesser morbidity, and recover better, from medical problems in general and psychiatric disorders in particular by adopting positive psychosocial techniques.

While Positive Psychology wants to capture the larger mandate of psychology: to make life better for all people, not just the mentally ill (Seligman, 1999[68]), Positive Psychiatry wants to capture the larger mandate of psychiatry of not just treating psychiatric symptoms, but enhancing well-being of those with mental or physical illnesses (Jeste, 2012[34]). While a psychiatric/psychosomatic disorder is 'part' of living, living well in spite of it is the 'art' of living, which Positive Psychiatry would like to explore and emphasize. This it does by identifying and incorporating those psychosocial factors in its psychotherapeutic and other interventions that make psychiatric and other medical patients function optimally *inspite* of their disorders.

A partial distinction also rests in the fact that Positive Psychiatry, as a branch of medicine, is more centrally and consciously rooted in biology. The goal of Positive Psychiatry is not only to identify and promote positive psychosocial factors, but also to understand their neurobiological underpinnings (see, for example, the attempt of Moore *et al*., 2015; p 261-284[58]).

It maybe pointed out in passing here that, in contrast to the Humanistic Psychology movement of the mid-20th Century, both Positive Psychology and Positive Psychiatry share a strong emphasis on the importance of quantitative data. (It should also be noted, however, that some contemporary adherents of Humanistic Psychology criticize the validity of the latter distinction; see, for example, Freidman, 2012[19]).

To summarise. While both Positive Psychology and Positive Psychiatry share a common bond of depending on quantitative data based on experimental evidence, Positive psychology largely depends on quantitative data from *normal* population, whereas Positive Psychiatry largely depends on quantitative data from *patient* population. Whereas Positive Psychology tends to largely correlate it with *normal* psychology, Positive Psychiatry seeks to largely correlate it with wellbeing in spite of *psychopathology*, at the individual, psychosocial and neurobiological levels.

6. Positive Mental Health, Connect-disconnect and Boundaries

Positive Mental Health is a super-ordinate category that includes both Positive Psychiatry (which predominantly studies the abnormal, and also some of the normal) and Positive Psychology (which predominantly studies the normal, and also some of the abnormal). It involves work and research in the fields of Psychology, Psychiatry and interdisciplinary studies.

In other words, if Positive Mental Health is the parent, Positive Psychology is the elder and Positive Psychiatry the younger sibling. (This is a relational construct between the branches, not necessarily accurate chronologically between the parent and the 'off springs'.)

Why such a distinction at all? It is necessary to demarcate areas of connect and disconnect so that there is no unnecessary blurring of boundaries, all branches

know what are their legitimate domains, where they should avoid transgressing, where they need to positively interact with, and impact the other, even whilst staying within their boundaries.

Of course the boundaries between Positive Psychiatry and Positive Psychology are necessarily porous at present, like a semi-permeable membrane, for both are in an interesting state of flux. Even if that be so, for the long-term growth of both, and their umbrella branch – Positive Mental Health – it is necessary for each to know their fundamental strengths and boundaries, so the synergy of the present carries forward into the future.

History of Positive Psychology and Positive Psychiatry

A brief look at the historical development of Positive Psychology and Positive Psychiatry will help grasp the rationale and justification for their development. This will also serve as a good spring-board for a study of the bioethics of Positive Psychiatry.

The study of positive mental attributes dates back at least as far as William James in the late 19th and early 20th Century, as well as other early 20th century leaders such as Terman and Jung. However, in the aftermath of World War II, the focus of psychology and psychiatry largely narrowed to the study and treatment of mental disorder (Linley *et al*., 2006[49]; Seligman and Csikszentmihalyi, 2000[70]). Even in the mid-20th century, there were strong proponents of studying and promoting human strengths, most notably the Humanistic Psychologists such as Maslow and Rogers. Nonetheless, as mentioned earlier, the 1998 Seligman American Psychological Association Presidential Address is generally acknowledged as a pivotal moment in the growth of the field of Positive Psychology over the past two decades (Linley *et al*., 2006[49]). Seligman called for 'a reoriented science that emphasizes the understanding and building of the most positive qualities of an individual: optimism, courage, work ethic, future-mindedness, interpersonal skill, the capacity for pleasure and insight, and social responsibility.'

In the subsequent decades following his call to action, Positive Psychology has grown into a strong, international, transdisciplinary, empirically grounded movement. However, with some noted exceptions, including the important contributions of Valliant (2011[90], 2012[91]), and Cloninger (2006[12], 2012[13], 2013[14]), psychiatry has largely remained focussed on diagnosis and treatment of psychiatric disorders. But, in his 2013 Presidential Address to the American Psychiatric Association, Jeste noted, 'I expect that the future role of psychiatry will be much broader than treating psychiatric symptoms. It will seek to enhance well-being of people with mental or physical illnesses. That is positive psychiatry.

We will learn more about brain processes responsible for these traits, and we will seek new ways to promote resilience, optimism, and wisdom through psychotherapeutic interventions.' (Jeste 2013, p. 1105[35]).

The rationale for the development of Positive Psychology and Positive Psychiatry

After all, why the need for such a development?

Psychology, being a sister discipline of Psychiatry, has concentrated on study of the normal, but has always been also concerned with having its say in abnormality. This it did by developing psychological tests that aided psychiatric diagnoses, as well as developing branches like Abnormal Psychology and Health Psychology, while playing its role in Behavioural Medicine. However, the concern over working beyond diagnostic categories, as also towards well-being and nurturing positive psychological traits and states, has always been of concern to the branch. This crystallized in the subspecialty called Positive Psychology following the Seligman 1998 Presidential Address.

What about Positive Psychiatry? Psychiatry has always concentrated energies on understanding abnormality. There has been a well-intentioned refrain that a psychiatrist's orientation is about, and expertise over, psychopathology, and therefore psychiatry must refrain from entering territory over which it has little, or no, expertise. A prudent stand is that a psychiatrist should desist from applying his concepts based on psycho-morbidity to human behaviour as a whole, something with which he has no special acquaintance. 'His day to day work is primarily with persons behaving in an abnormal or at least unusual way, and this gives him a bias in perspective' (Slater and Roth, 1986; p 6[77]). This is also reflected in the writings of Freud who thought of mental health or normal ego as 'ideal fiction', and Adolf Meyer who said we should stop 'moralizing' about utopian mental health (Lief, 1948[45]). And yet, at the same time, there has always been a parallel and clear movement for the expansion of psychiatry's reach beyond psychopathology. The whole Humanistic-Existential approach and even some of the Neo-Freudian movements were efforts in that direction, starting with Maslow, Perls, Sullivan and continuing with Erikson and the rest. The need to achieve well-being, and the concept of mental health rather than psychiatric disorder, are concepts that developed from such a forward thrust.

The physician-psychiatrist's justified bias towards study of and expertise over psychomorbidity needed to be balanced with study and delineation of those factors and processes that pre-empt, or reduce, the manifestation of such psycho-morbidity. That led to the birth of Positive Psychiatry.

The parallel between the 1998 Seligman's Presidential Address on Positive Psychology to the American Psychological Association and the 2013 Jeste Presidential Address about Positive Psychiatry to the American Psychiatric Association, is not hard to grasp.

In the development of Positive Psychiatry, there is much that assimilates and categorises what is already present as data and practice in the branch of psychiatry. However, by forming a new subspecialty, it gives that much needed focus and forward thrust to the measures that will go to make this subspecialty, as also the branch of psychiatry itself, vibrant.

Fundamental justification for Positive Psychiatry

The fundamental justifications for Positive Psychiatry are, therefore, basically three:

1. Identifying Positive Psychosocial Factors or PPSFs

To look for those attributes in the person and his environment which positively impact and modify an individual patient's response to his medical condition, psychiatric or otherwise. In other words, Positive Psychosocial Factors or PPSFs. This is important because it is what affects recovery and restitution beyond what a physician/psychiatrist usually does with his procedures and his medications. In fact, it is what aids in the better recovery of one patient over the other, all other factors being similar.

For example, the same physician/psychiatrist treats two different patients. Let's take it, both have the same psychiatric disorder with the same level of psycho-morbidity. One shows better recovery than the other. What are those psychosocial factors that aid one patient's recovery over that of the other? What aids his adjustment to his disorder, what helps him become a better integrated person, both internally and with his community?

2. Importance of individual Positive Psychosocial Factors

It will potentially identify for the treating physician/psychiatrist which individual positive factor in personality/environment to harness/enhance in handling the individual patient. Should Optimism be enhanced to reduce psychomorbidity in the psychoses? Does Resilience enhancement help reduce cognitive decline in neurodegenerative disorders like Alzheimers? Does greater Social Cooperativeness retard the cognitive decline of aging to positively impact all chronic disorders? Do Self-transcendence and Wisdom help a recovered patient of the psychoses remain relapse free?

All these are pointers to many further studies which will tease out their details and help enhance patient wellbeing.

3. Informed choice between Positive Psychosocial Factors

It will also potentially help decide between various interventions in disorders and individuals. What works better in a particular disorder, promoting Resilience or Optimism? Encouraging Social participation or Spirituality? Also the patient's choice in these matters helps decide what intervention to pursue. If the patient is irreligious but believes in being socially active, the choice of intervention is already made. If the patient is Resilient but has less of Wisdom, the choice is obvious.

In other words, when there is an either-or situation, it helps the physician make informed choices.

The paradigm shift and bioethics

The brief peep above into their histories and a brief understanding of the rationale and justification for their development makes it clear that the paradigm shift that both Positive Psychology and Positive Psychiatry champion is:

- Going beyond psychopathology to well-being in the normal population (Positive psychology); and
- Going beyond psychopathology to well-being in the patient population (Positive psychiatry).

  Between them, they cover the entire gamut of the population to be served, with the final result being:
- Going beyond psychopathology to well-being in the general population, both normal and sick (Positive Mental Health).

This fundamental paradigm shift is of concern to Bio-ethics because it touches the issue of how Science (here Medical Science) tries to broaden its vision to achieve its larger goal of serving the common good, in spite of its rather rigid practices and self-imposed circumscribed sphere of influence.

Why should Bioethics be Interested in the Positive Factors that Support Positive Psychiatry

Ordinarily, Bioethics has been occupied, with some justification, with pointing out faults and limitations and sounding cautionary notes over processes and procedures that medical personnel may either not realize or covertly/overtly subvert/acquiesce in, because of their eagerness to move on with their work. The major thrust of Bioethics has been to act like a watchdog, an activist, to point out faults, and help set limits.

While this is of course important, it is also the business of Bioethics to point out why, and how, if at all, a process/procedure is legitimate, and when it

becomes illegitimate. For ethics is concerned with both *proper* and improper, both *good* and bad.

Part of the reason why bio-ethicists may not be taken seriously, or get taken unduly seriously, is because they are busy pointing out faults, as though there were no merit in the processes they evaluate. While a bioethicist need not be a campaigner or pamphleteer for any cause, he must be equally concerned with what is good and proper about a branch, even while pointing out its fault and drawbacks. He must provide that much needed balance, which a committed proponent of a branch obviously, and understandably, cannot provide; and also a committed critic can also obviously never provide.

The Four-principled approach, or Principlism

To help the uninitiated make sense of further discussions, we shall first give a brief outline of the four-principled bio-ethical approach often called 'Principlism', with explanation of other four related concepts of 'Common morality', 'Specific morality', 'Specification' and 'Balancing'. We shall briefly touch upon Hare's formulation to achieve Balancing. We shall then see what is proper and good about Positive Psychiatry, and scrutinize its limitations. We will evaluate both these on the basis of the 4-principled approach and the related four concepts, and the concept of 'Double effects'.

1. A brief outline of Principlism

Let us first understand what are the bioethical concepts in what is called 'Principlism', and the related concepts of 'Common morality', 'Particular morality', 'Specification' and 'Balan`cing'. The connected concept of 'Double effect' needs to be understood too, which will be taken up later.

Principlism

Beauchamp and Childress' (2009[5], 2013[6]) seminal work in biomedical ethics, *Principles of Biomedical Ethics*, details an approach, often simply called *Principlism*, which contains four biomedical ethical principles: (1) Beneficence, (2) Non-malfeasance, (3) Autonomy and (4) Justice.

(1) Beneficence i.e. patient welfare, '*Salus aegroti suprema lex'*, means a medical practitioner should act in the best interest of the patient. In other words, patient welfare comes first, all else depends on it. For example, The Preamble to the Principles of Medical Ethics, American Medical Association, 2013[2], gives centrality to the benefit of the patient first, then of society, other health professionals, and of self, in that order: 'The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician

must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self' (American Psychiatric Association, 2013[2]).

(2) Non-malfeasance i.e. no harm, '*primum non nocere*', or 'first, do no harm', means even if a practitioner cannot do good, he should never do his patient harm. Some 'hurt' is understandable as part of a procedure, but 'harm' is never permissible (Singh and Singh, 2006[73]). For example, a surgeon's incision 'hurts', but is sanctioned under the principle of beneficence since it is meant to carry out a much needed surgery. But the same incision 'harms' when it is meant to carry out an organ removal without the patient's knowledge and consent and thus violates the principle of non-malfeasance.

(3) Autonomy, i.e. consent, '*Voluntas aegroti suprema lex*' means the patients have the right to refuse or choose their treatment. Coercion, forced or subtle, is out.

(4) Justice, i.e. fair treatment to all, concerns the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality). Also, every patient must get fair treatment irrespective of caste, creed, religion, nationality etc. Fair treatment is based of a code of professional ethics and relevant evidence based procedures and practice guidelines.

In other words, a medical practitioner works primarily for the welfare of his patient, should never cause harm, even if he cannot bring about care and comfort, should respect the patient's right to chose/refuse treatment, and should give fair treatment irrespective of geographical/cultural/ideological/religious considerations (See Case Vignette 1).

Case Vignette 1: Following the 4-principles in medical practice

Dr. Z often prays, not that he should have more patients in his hospital, but that he should have the capability to do his best for whosoever comes to him. He never suggests surgery when conservative treatment can serve the purpose e.g. he always motivates his patients to consider normal childbirth rather than adopt the easier option of an elective caesarian section [Beneficence]. He never sends patients for unwanted procedures like costly investigations, or unduly alarms them into hospital stay, to inflate ancillary bills and make resultant profits [Non-malfeasance]. He insists of giving full relevant information before any procedure is carried out, and performs it only after obtaining an informed consent [Autonomy]. He treats patients of an inimical community with the same care as he does his own [Justice].

Dr. Z can be said to be following the 4-principles in his medical practice.

2. Common morality

The 4 biomedical principles explained above combine with ethical virtues and some general rules to form the starting point and framework of ethical decision making called '*Common morality*'. It is the set of norms shared by all persons committed to ethics. It is not merely a*n* ethic, in contrast to other ethicalities. It is applicable to all persons in all places, and we rightly judge all human conduct by its standards. (Beauchamp and Childress 2009; p3[5]). For example, the ethical principle that all physicians, irrespective of their geography, should work for the welfare of patients (Beneficence).

In other words, general rules of ethics, or universal ethics.

3. Particular morality

As different from 'Common moralities', which contain universal ethical norms, 'Particular moralities' contain non-universal ethical norms that arise from different cultural, religious, and institutional sources. While 'Common moralities' are general and content-free, 'Particular moralities' are concrete and content-rich. For example, where sophisticated treatment processes are not available, it is perfectly ethical to carry out the best of what is: if facilities for laparoscopic surgery are indicated but not available, it is ethical to carry out open surgery. Also, cultural, religious, and institutional sources come into play here. For example, when an American Christian physician handles a Chinese Confucian patient, he should expect his patient's opinion on death, rebirth and immortality maybe very different from his, and respect the patient's right to take end-of-life decisions so based. 'Particular morality' gives *how* should physicians work for the welfare of their patients, what should they do, and what not. Which special class, and culture, of patients needs what handling.

While 'Common morality' gives general rules of ethics, 'Particular morality' gives how these general rules are applied in particular cases. While the former is more non-empirical and absolutist, the latter is more empirical and utilitarian.

In other words, these are particular rules of ethics that work in specific situations; to that extent, they are examples of non-universal ethics, though of course with roots in universal principles.

4. 'Specification' and 'Balancing'

These are the two means by which '*Common moralities*' are enriched with empirical data from the '*Particular moralities*'.

Specification

It is ethical principles in actual practice. It is a '…a methodological tool that adds content to abstract principles, ridding them of their indeterminateness and providing action-guiding content for the purpose of coping with complex

cases. Many already specified norms will need further specification to handle new circumstances of indeterminateness and conflict' (Beauchamp 2011, p 301[4]).

In other words, it gives the content relevant to a specific context. For example, which ethical code to adopt, which ethical/clinical practice guidelines to accept, which cultural norm to consider inviolate in treatment (See also Case Vignette 2).

Balancing

It is what to do and what avoid, as also balancing and adjudicating between two 'goods'. To develop sound judgment and act according to justice. It is important for reaching sound judgments in individual cases and is 'the process of finding reasons to support beliefs about which moral norms should prevail' (Beauchamp and Childress 2009, p 20[5]). For example, what is better in a certain case - to reduce intolerable pain in terminal cancer by a procedure (Beneficence), which may increase morbidity and remotely even cause mortality (Non-malfeasance), or just allow the patient to suffer because of a justified concern it can cause mortality (Justice). Also worth noting is that since the particular ethicalities are different, people sometimes specify and balance the principles differently. Hence the principlists' claim 'that there can be different and equally good solutions to moral problems' (Gordon, 2011, p 299[25]). For example, what do we do with life support systems in a patient with a permanent vegetative state? Both removing it, and continuing it, are justified from different standpoints, and so appear equally good. Balancing between primacy to life (absolutist stance) or giving a dignified exit to a life no longer worth living (utilitarian stance) will depend on the belief system of the patient/relatives/physician and law of the land (See also Case Vignette 2).

Case Vignette 2: How Specification and Balancing work

Dr. A is a psychiatrist in the US. He is a member of the APA. The APA endorses the Code of Medical Ethics with Annotations especially applicable to Psychiatry. The APA also issues ethical and clinical practice guidelines from time to time for its members. Dr A studies recommendations of the Code and the Guidelines and applies it in his practice. This is specification.

Dr. A has 2 patients facing terminal cancer. One patient's belief-system is that life cannot be terminated howsoever painful it may be e.g. Christian. The other's belief-system allows him to terminate life by prescribed means when it becomes an endless suffering, and all goals have been achieved e.g. Indian Jainas' Samlekhana or Santhara. Dr A will be guided differently in advising any euthanasia processes in these two patients. He will need to balance his ideal of supporting life with the cultural belief of the individual patient. This is balancing.

5. Hare's formulation to achieve Balancing

In cases of ethical dilemmas where we have to decide between two or more competing 'goods' and where we are looking for a master principle in cases of

their conflict, Hare's (Hare, 1981[28], 1984[29]) formulation is useful to achieve the necessary 'Balancing'. Put simply, it says that when ethical conflicts arise, no one-level account can solve the problem. For example, it is generally proper to tell the truth. But will we tell the truth if someone is hiding in our house and a murderer is at the door asking for him? If conflicts arise at one level, they cannot be resolved without ascending to a higher level. At the intuitive level of thinking, the absolutist stance is appropriate e.g. telling the truth, or saving a life. But it no longer remains sufficient when conflicts arise between absolutist stances e.g. whether to tell the truth or save a life. Then ascending to the critical level of thinking of the utilitarian alone can help. We select thereby the principles to be used at the intuitive level, and adjudicate between them in cases where they conflict. For example, the utilitarian adjudicates between two 'goods' in this case i.e. telling the truth or saving a life, and decides that saving a life is better than telling the truth.

We shall see later how this helps in 'Balancing' when applied to Positive Psychiatry.

6. Objections to the 4-Principled approach, and Answers to those Objections

The four-principled approach is the most widely used and authoritative bio-medico-ethical approach, and is what we shall use here. But it must be noted that there have been some well-intentioned objections to its use:

1. That it is methodologically faulty and a mere checklist
2. There is no master principle in cases of conflict among these principles (Gert and Clouser, 1990[22]); and
3. That its universal principles have still to be validated cross-culturally (Takala, 2001[82]; Westra *et al*., 2009[93]; Gordon, 2001[25]).

The answer to the first objection is that although the 'Common moralities' of beneficence, non-malfeasance, autonomy and justice appear like a checklist, when we add the 'Particular moralities' of cultural, religious and institutional sources, it no longer remains just a checklist. It becomes a useful means to assess and adopt specific processes in specific cases on the basis of ethical principles. Moreover, the aspects of 'specification' and 'balancing' add further content and finesse to the biomedical ethical entity studied. 'Specification' adds ethical codes, clinical practice guidelines etc. Balancing helps adjudicate based on cultural and utilitarian values in individual cases.

Answering the second objection, 'Balancing' aids decision-making: it helps decide between two or more competing goods. It also acts as a master principle in cases of conflict. Hare's formulation to achieve 'balancing' discussed above is an example.

The answer to the third objection is that even as 'Common moralities' of beneficence, non-malfeasance, autonomy and justice need cross-cultural validation, the same can be said for all universal principles, which argument

cannot become the basis of their rejection. In matters such as these, till we have valid universally accepted cross-cultural confirmation, we must look at their *prima facie* and provisional validity, and proceed with laying down *working hypotheses*, which we provisionally accept, and will always be ready to abandon in the face of contrary evidence. For science to progress, 'it needs *working hypotheses* in order to grasp and dissect its experiences; and no harm is done if these hypotheses are only partial, or even faulty, provided they are invariably regarded with skepticism (Slater and Roth, 1986, p 27[77]). Moreover, 'the sciences do not advance solely by the accumulation of ever more facts; it is also necessary to arrive at statements of an increasing generality, to provide modes of interpretation, i.e. hypotheses, of an increasing extensive explanatory and predictive value' (Slater and Roth, 1986, p xiv[77]).

In other words, irrespective of well-intentioned criticisms, we need the four universal biomedical ethical principles, for they offer working hypotheses, and there are no refutative or competing hypotheses as of now.

We shall now use these principles to help make sense of the fast emerging facts about Positive Psychosocial Factors in the field of Positive Psychiatry. But before that, we must survey the positive findings.

The Case for Positive Psychiatry: the Salient Research Findings

1. The Findings in Favour of Positive Psychiatry

The progress of Positive Psychiatry in recent times has been dotted with numerous studies showing its positive impact. Also, a number of Positive Psychosocial Factors have been identified and validated by quantitative studies and meta-analytic reviews. Prominent amongst these are qualities like Resilience (Stewart and Yue, 2011[80]), Optimism (Rasmussen *et al*., 2009[63]), Personal mastery (Mausbach *et al*., 2007[51]), Wisdom (Jeste and Harris, 2010[36]), Religion and spirituality (Vahia *et al*., 2011[88]), Social relationships and support (Holt-Lunstad *et al*., 2010[32]), and Engagement in pleasant events (Uchino, 2006[85]).

There are a growing number of studies suggesting that such positive factors are tightly linked to human biology, specifically neuroscience, genetics, and epigenetics, involving interactions among genes, environment, and structure and function of the brain (Jeste, 2012[34]). For example, the biological roots of Optimism, Resilience and Wisdom have been studied. Genetic-association studies have linked Optimism to the oxytocin receptor gene, as well as to the 5HTTLPR variation in SLC6A4, a gene responsible for serotonin transport. Other studies have shown that 5HTTLPR and hypothalamic-pituitary-adrenal axis genes are related to Resilience. Neurocircuitry of Wisdom may involve the prefrontal cortex (especially dorsolateral, ventromedial, and anterior cingulate) and the

limbic striatum — the newest and the oldest parts of the brain, respectively, from a phylogenetic or evolutionary perspective (Jeste, 2012[34]).

Moreover, as we shall see later, these positive factors are associated with significant positive health outcomes exemplified by longevity, better functioning, and reduced susceptibility to psychiatric disorders like depression, as well as to cardiovascular, metabolic, and other physical diseases (Jeste, 2012[34]). Positive psychological factors are a stronger predictor of outcomes such as self-rated successful aging than is physical health (Strawbridge *et al*., 2002[81]).

Several of these positive psychosocial factors have also been shown to have a positive effect on survival that rivals or exceeds that of well-established health risk factors such as smoking, hypertension, obesity, and sedentary lifestyle (Rasmussen *et al*., 2009[63]). This, in essence means that the effect of well established health risk factors can be offset by positive psychosocial factors [See Case Vignette 3].

Case Vignette 3: Health risk factors offset by Positive Psychosocial Factors

Mr. X, is an obese 71 year old writer who hardly moves out of his house and exercises poorly, drinks 2 pegs of whisky every evening and smokes 5 cigarettes a day (Health risk factors). He has mild hypertension for which he takes a morning maintenance dose of Atenolol 50 mg.

Mr. X has never got admitted to hospital. He writes for 4-6 hours daily, waking up early morning to do so, and never misses writing deadlines. When a newspaper he edited and made immensely popular suddenly closed down, he just moved on and started writing syndicated columns (Resilience). He is known to always look at the bright side of things. He often jokes that if the newspaper had not booted him out, how would he have started his syndicated columns and made so much money (Optimism). He is not overly dependent on others for his needs. He makes his own breakfast and at times his own meal (Personal Mastery). He enjoys cracking jokes, and the company of pretty women (Engagement with pleasant events). He also enjoys meeting people from different strata of society at an 'open house' every evening at his home (Social connectivity). With appointment he is also known for giving sage advice (Wisdom). He takes care that doctors and a full time nurse tend to his wife, who is showing progressive signs of Alzheimer's disease. He does not allow the inevitable deterioration in her condition to affect his work or leisure schedule (Resilience).

In spite of health risk factors like obesity, lack of exercise, smoking, alcohol, and the poor prognosis sickness of a loved one, positive psychosocial factors like optimism, resilience, self mastery, wisdom, engagement in pleasant events and social connectivity have helped offset negative health risk factors.

This of course does not mean that one voluntarily adopts health risk factors and then off sets them by positive psychosocial factors. It just means the latter have such powers.

2. Resilience

Studies among physically ill patients have shown resilience to be associated with improved health-related quality of life, as well as with medically desirable behaviours or outcomes such as self-care, treatment adherence, exercise adherence, and improved physical health (Stewart, 2011[80]). Optimism has been studied in the context of a number of serious medical conditions including cardiovascular disease and shown to be associated with less illness-related distress, higher quality of life and satisfaction, and lower incidence of depression (Carver *et al*., 2010[11]). The positive interplay of resilience and optimism aids recovery, while their absence has negative consequences. (See Case Vignette 4).

Case Vignette 4: How Resilience and Optimism aid Recovery

Mr. X (67 years) and Mrs. X (66 years) both have type 2 diabetes and had their first myocardial infarction nearly 9 years back, within 6 months of each other (He first, and she later). Before their ailment, both were non-exercisers, had poor diet control, and had frequent late night parties.

Mr. X is the eternal optimist while Mrs. X is the perfect example of a pessimist. He adjusts to changed situations quickly, forgiving people and forgetting hurtful events (Resilience). Mrs. X finds it very difficult to adjust to changed situations, never forgives or forgets and keeps nursing past hurts and resentments (Non-resilience).

Following the ailment, Mr. X goes for a 30 min morning walk regularly as per the physician's recommendation, never misses his scheduled check-ups, has given up smoking and regulates his diet as per the dietician. He also goes for an hour to the garden in the evening to spend some pleasant time with his friends, chatting in a relaxed manner over anything under the sun. He has an occasional late night party but doesn't crave for it. Nor does he crib about losing out on all the fun.

Mrs. X, on the other hand, does not exercise, does not go for regular checkups in spite of her husband's prodding, continues to default on her diet by gorging on sugar rich sweets and ice-creams. She avoids the late nights too but keeps cribbing about missing all the fun because of her ailment. She continues with her occasional kitty parties but keeps finding fault with others and returns home upset.

Mr. X has been an eternal optimist. He smiled in and out of the ICCU. He joked on entering there, 'Ah, just proves I have a heart that can go wrong – like that of any teenager!' He maintained his cool while emergency procedures were carried out there. He has since taken charge of his ailment and voluntarily follows whatever good advice his physician and dietician give.

Mrs. X was the exact opposite in the ICCU. She made her stay there a nightmare for the staff and her relatives by her constant cribbing. She continues to whine daily about the unkindness of her lot, keeps finding excuses for not doing exercise and following a diet, and blames the doctors and her husband for her plight.

Their doctor advised them to do yoga for control of diabetes and to improve their cardiovascular functioning. Both joined enthusiastically. While Mr. X completed the course and continues doing it regularly, Mrs. X gave up the course midway, saying it was too 'boring'.

Mr. X's diabetes is well under control, he is only minimally over weight, and has not suffered a CV episode again in the next 9 yrs. He was out of the ICCU in 3 days. Mrs X has uncontrolled diabetes, has become grossly overweight, and has suffered 2 more myocardial infarcts, for all three of which she had prolonged ICCU stays. She has since developed greatly compromised cardiac function.

Mr. X's resilience on knowing his ailment (changing his lifestyle to suit recovery) and his optimism that recovery is possible help him sustain positive amends in lifestyle which aid his recovery and lead him to experience well-being in spite of his ailment.

Mrs. X's non-resilience (sticking to old maladaptive patterns of behaviour) and her pessimism do not allow her to sustain amends in her lifestyle, obstruct her recovery and her well-being, and prevent her from reaching a state of well-being. In fact they contribute directly to her morbidity and her relapses.

Resilience and Optimism amongst the elder age group is found especially useful (see Case vignette 3 and 4 above). Numerous studies on Resilience and Optimism have been reported to be associated with a lower risk of all-cause mortality in longitudinal studies of older adults (Giltay *et al*., 2004[24]; Steptoe and Wardle, 2005[79]). People in their 90s who endorsed higher levels of Resilience had a 43% higher likelihood of living up to 100 years compared to their peers with lower Resilience (Shen and Zeng, 2010[76]). Resilience is associated with better emotional health and self-rated successful aging and with less pain and better health-related quality of life in older adults (Lamond *et al*., 2008[44]; Zeng and Shen 2010[95]; Tomas *et al*., 2012[84]). Optimistic older adults report higher levels of well-being and are more likely to engage in healthy behaviours than others (Giltay *et al*., 2007[23]). A meta-analysis of 83 studies of Optimism found a significant relationship between Optimism and physical health outcomes including cardiovascular outcomes, physiological markers (including immune function), cancer outcomes, outcomes related to pregnancy, physical symptoms, pain, and mortality (Rasmussen *et al*., 2009[63]). On the other hand, low Optimism has been associated with increased loneliness and increased inflammation markers among older men (Rius-Ottenheim *et al*., 2012[64]; Ikeda *et al*., 2011[33]).

3. Engagement in Pleasant Events

A close association between Optimism/Resilience and Engagement in pleasant events is obvious: those who are optimistic and resilient are most likely to engage in pleasant events (e.g. the evening get-together by the writer in Case Vignette 3, and meeting friends in the garden by Mr. X in Case Vignette 4; see also Case Vignette 5). Studies have reported direct association between engagement in pleasant events and both mental and physical health, including reduced cardiovascular disease risk (Lewinsohn and Libet, 1972[47]; Lewinsohn and Graf, 1973[46]; Mausbach *et al*., 2008a[52]; Mausbach *et al*., 2011[54]; Mausbach *et al*., 2012[55]; von Känel, 2013[92]). Numerous articles show buffering effects of social engagement on depressive symptoms, cardiovascular health, cancer recovery, and dementia (Uchino, 2006[85]).

4. Strong social relationships and social support

a. Strong social relationships

A relatively recent meta-analysis of 148 studies (N > 300,000) found a 50% increased likelihood of survival among participants with strong social relationships compared to those without, and these finding were largely consistent across different groups based on age, gender, initial health status, cause of death, and follow-up period (Holt-Lunstad *et al*., 2010[32]). Research over the past three decades has firmly established an association between the quality and quantity of one's social relationships and health outcomes (Umberson *et al*., 2010a[86]; Umberson and Montez, 2010b[87]) (See Case Vignette 5).

Case Vignette 5: How social relationships and social support combine with resilience and engagement with pleasant events to keep her healthy

Ms. M, a 75 yr old widowed businesswoman, lives alone with servants who look after her household. Her husband expired 8 yrs ago due to heart failure. Her son and daughter live in different cities and have often invited her to shift residence with them, but she enjoys her autonomy and single living, and will not compromise her 'pride' by depending on others.

After her husband's death, she took over the family owned business and joined a music group with strong interpersonal bondings (Resilience, Strong social relationships). The group meets at least twice a month formally, and 3-4 times informally at each others' residence for evening long musical soirees. She takes active part in all these, and often invites the group over to her residence. Her mornings are full of music practice and preparation for the next programme, besides attending to her business. Her evenings are often with friends from the music group, or having friends and relatives over for dinner. Or watching a first day first show release of a movie, either alone or with a friend from the same group (Engagement with pleasant events).

When she had her knee replacement surgery, the members of this musical group took turns to look after her in hospital and later at home (Strong social support).

The strong social bonding of belonging to this group added meaning and purpose to an otherwise lonely life. She enjoys a morbidity free life, with just a statin to keep her cholesterol in check. The quality and quantity of her social relationship and social support, along with her optimistic outlook and resilience, have helped take care of her loneliness, kept her healthy and added to her feeling of wellbeing.

b. Social support

A number of studies have demonstrated a significant association between strong social support and reduced prevalence or severity of depression, anxiety, substance use disorders, hypertension, cardiovascular disease, and dementia, as well as longer survival (Uchino, 2006[85]). (See Case Vignette 5 above and 6 below).

Case Vignette 6: How a vibrant social circle, intimate connection with society's welfare, self-transcendent attitude, sharing wisdom and having a deep spirituality aid longevity

Mr. X is celebrating his 90th birthday with his wife Y aged 84. They still court each other, are the first to hit the dance floor, and enjoy socializing with friends and family. They take pride in helping friends in need, and are part of an activist group that helps destitute children and senior citizens find shelter (Self-transcendence). Every year they sponsor higher education for 2 students, one for post-graduation in the country, and one abroad. They have thus helped a large number of young aspirants for whom they are like foster parents. Their wise practical advice is available to them all through life (Wisdom).

They have a large number of friends and well-wishers who were there to help X and Y when he had a myocardial infarction at 66, and when Y had a hip fracture following a fall at 71 (Social support). Both the times, their children were abroad and only landed up after the critical phase was under control.

Mr. X and Ms. Y are also deeply religious and offer gratitude for their long and vibrant life to their parents and to God (Spirituality). During all their difficulties, they were confident that the Almighty would help them sail through.

Mr. X and Ms. Y have a vibrant social circle and are intimately connected with society, have a self-transcendent attitude in consistently helping others, share their wisdom and are deeply spiritual. All these positive factors aid their longevity.

5. Religious and spiritual practices

Religiosity/spirituality is associated with better lipid profiles as well as lower blood pressure/less hypertension and better immune function. Some investigations find spirituality to be associated with decreased levels of cortisol (Seeman *et al*., 2003[67]; Koenig *et al*., 2001[42]).

Religious and spiritual practices are reportedly associated with greater well-being as well as better health outcomes throughout the lifespan (Vahia *et al*., 2011[88]; Vance *et al*., 2011[89]). Meta-analysis suggests a significant positive relationship between religiosity and subjective well-being, including greater life satisfaction and stronger reports of self-actualization (Witter *et al*., 1985[94]; Hackney and Sanders, 2003[26]) (See Case Vignette 6 above).

6. Wisdom

Some, but not all, studies suggest that an increase in wisdom with aging may be important for an older adult's ability to survive and even thrive in spite of worsening physical health. Wisdom transmitted to younger generations may provide a fitness advantage and help neutralize the loss of fertility in old age – the so-called Grandma hypothesis (Jeste and Harris, 2010[36]; Lahdenperä *et al*., 2004[43]). (See also Case Vignette 1 and 6 above).

7. Personal mastery

High levels of personal mastery protect individuals from the negative health effects of stress and improve subjective ratings of health (Mausbach *et al*., 2007[51]). It may protect individuals from the negative health effects of stress including higher concentrations of plasminogen activator inhibitor-1 antigen which are associated with an increased risk of thrombosis (Mausbach *et al*., 2008b[53]). In a sample of older caregivers of Alzheimer's patients, greater coping self-efficacy was associated with lower blood pressure and pulse pressure (Harmell *et al*., 2011[30]). (See also Case Vignette 7).

Case Vignette 7: How personal mastery works

Ms. B, a visually impaired senior citizen, insists on learning new techiques to master her impairment. She gently declines people's unsolicited help while crossing roads or attending functions. She has mastered the technique of looking after herself in most such situations. She is efficient in Braille and its latest versions. She has a trained dog to help her manoeuvre through most conditions. When in need of help, she promptly asks for it, but thanks a person out of any unsolicted, or unduly extended, help.

B is an example of personal mastery.

8. The Element of Subjectivity

Perceived stress is more critical than objective measures of stress in its impact on biomarkers such as telomere length (Epel *et al*., 2004[18]). Subjective well-being is correlated with reduced mortality and greater longevity (Diener and Chan, 2011[17]). (See Mrs. X as example of greater perceived stress, and Mr. X as example of subjective well-being in Case Vignette 4).

Positive Psychiatry and Applying the Principle of Beneficence

The bioethical principle of beneficence, which is the cornerstone of medicine, and its major, if not only, justification, is of interest here. All studies, interventions, research are justified only if this fundamental principle is upheld.

Does Positive psychiatry stand the test of beneficence?

In identifying personality characteristics like resilience, optimism, personal-mastery, engagement in pleasant events, strong social relationships and social support, religious and spiritual practices, wisdom etc as positive psychosocial factors which impact health outcomes and recovery, it is attempting to pinpoint those aspects which help recovery and are in the best interest of the patient. Therefore, it passes the test of beneficence well.

Case Vignette 8: Encapsulating the Positive Psychosocial Factors, and Highlighting a Psychiatrist's Role in applying them to bring about Beneficence

Ms. B, a 55 yr old businesswoman lost her husband in a car accident 15 years back. She was a home-maker before this. Following his sudden demise, she was devastated. She suffered prolonged grief and slipped into depression. She underwent psychiatric treatment wherein, along with medication, she was encouraged through psychotherapy to strengthen positive psychosocial factors, e.g. resilience, self-mastery and religiosity; and learn new ones like optimism, wisdom, and strong social relationships and social support.

She took over the reins of the family business, established herself as an alternative to her husband with the partners and clients, and brought up her two kids (Resilience). She took charge of her emotions and grief (Personal mastery) and became part of a religious group which had strong bonding amongst members (Strong social relationships and social support). Being a great believer in a certain spiritual sect, she regularly attended its weekly meetings (Religious and spiritual practices). Whenever in doubt, she sought guidance from her 'guruji', whose wisdom had always helped her sail through major obstacles (Wisdom). Diagnosed also with Type 2 Diabetes 4 years back, she controlled it with exercise, diet, yoga and single morning tab of a Metformin and Glimeperide combination (Personal-mastery). Her zest for life and looking to the brighter side of things never reduced through all this (Optimism).

Not wanting to take any risk with her mental health, she does visit her psychiatrist twice a year just to confirm all is well with her (Controlled optimism).

She managed her depression following strengthening of positive psychosocial factors by her psychiatrist (Beneficence). She manages her business, the education of her kids, her

own diabetes, by her sheer optimism, resilience, engagement in pleasant events, personal mastery, strong social relationships and social support, religious and spiritual practices and wisdom (Positive psychosocial factors).

Encouraging such and other positive psychosocial factors, finding their further nuances by scientific studies, and incorporating them into interventions that stand the test of beneficence, is the next step forward.

Before scrutinising the role of Principlism in other positive psychosocial factors, we must outline what are 'double effects' and what is their role here.

What are Double effects and how do they work in Positive Psychiatry?

Originating in Thomas Aquinas' ideas on homicidal self-defense, 'Double-effects' is a bioethical concept that refers to two types of consequences, one positive the other negative, that may be produced by a single action. When you defend yourself and in so doing kill someone, you save yourself (positive effect) but you kill someone (negative effect). In medical ethics it is usually regarded as the combined effect of a beneficence that can be potentially malfeasant. Often cited example of double effect is use of morphine or analogues in the terminal patient. Morphine has the beneficent effect of easing pain and suffering. Simultaneously, being a respiratory depressant, it can also have the maleficent effect of shortening the patient's life (Randall, 2008[62]).

How are 'Double effects' related to Positive Psychiatry? The next section will clarify this.

The Case for Caution: Double effects and other issues with Non-malfeasance, Autonomy and Justice

Even though positive psychosocial factors such as optimism, resilience, wisdom etc are useful for the individual and the society, there are several potential ethical issues of concern in the practice of Positive Psychiatry. Although data supports the principle of beneficence, there are other principles to be fulfilled as well, the principles of non-malfeasance, autonomy and justice, and taking care of potential double effects.

1. Non-malfeasance and Positive Psychiatry

How does Positive Psychiatry stand with regard to non-malfeasance? Can it harm? Let's take the case of optimism for which there is extensive support as a positive psychosocial factor and look at some potential double effects.

2. The Double effects with Optimism

Every positive factor can have a potential downside. The same applies to

optimism. For example, people who are too optimistic may indulge in unwanted risky behaviours because of a belief that they would somehow survive due to their optimistic attitude (*double effect*). This amounts to 'pseudo-optimism' and such a person often labels other derogatorily (*pseudo-optimistic labelling)*. It may result in neglect of risk factors and warning signs, even if the patient is a properly informed person (*double effect*). A '*controlled*' optimism, even a '*controlled*' pessimism, may be more advisable in certain situations (See Case Vignette 9 below; also 8 above).

Case Vignette 9: Controlled pessimism and Controlled optimism better than Pseudo-optimism or Pseudo-optimistic labelling

Mr. D was explained the warning signs of a heart attack after an earlier angina attack and angioplasty. He shrugged it off when he developed retrosternal pain a year later, saying it was just 'gas' and it often happened to him ('pseudo-optimism'). He held the opinion that doctors unduly alarmed patients so they could make more money (pseudo-optimistic labelling).

His wife was more realistic. However, she was often labelled by him as unduly alarmist because, according to him, 'she takes medical advice rather too seriously, thinking of the worst case scenario immediately' (pseudo-optimistic labelling).

Not trusting her husband's bravado, she called her son. Fortunately, the son, a doctor, was around. He immediately rushed him to the ICCU, and Mr. D was found to have developed extensive myocardial infarcts. He was immediately put on emergency measures and survived.

His 'pseudo-optimism' would have cost him his life.

His wife's 'controlled pessimism', which made her aware of a perilous situation, seemed better in this situation.

His son had 'controlled optimism', for he heeded the warning signs, but was optimistic prompt treatment would help his dad.

And so it happened.

Psychiatric counselling for depressive symptoms later could convince the patient to move from 'pseudo' to 'controlled optimism'.

It is necessary to promote only 'due' optimism for the sick: an optimism which helps patients see the brighter side of things, believe in their recovery, help them face difficult situations with humour and courage; but prevents false bravado and treatment non-compliance by a '*pseudo-optimism*' and '*pseudo-optimistic labelling*. Promoting blanket optimism without clarifying its nuances can amount to malfeasance (double effect).

3. The Double effects with Resilience

Let's take the case of another positive psychosocial factor: Resilience. Numerous studies show its positive side, but future studies may show its downside – e.g. excessive pain tolerance/resilience may lead to delayed diagnosis of cancer until it becomes inoperable (double effect). This amounts to 'pseudo-resilience', the result of a 'pseudo-optimism' often born out of 'denial' (See Case Vignette 10).

Case Vignette 10: Pseudo-resilience born out of Pseudo-optimism which often masks Denial

Dr. G a physician was suffering extensive weight loss for 1 yr. Acquaintances who meet him infrequently were alarmed at his weight loss and his looks of premature aging. However his family members could not make out since they saw him day to day, though his wife did notice his weight loss and told him to meet a doctor. He brushed her aside, saying he himself was one (Pseudo-resilience born out of Pseudo-optimism).

He still managed to enjoy his work and workouts, saying good-humouredly he could now eat anything and not put on weight. He also felt excessive thirst and laughed it off, saying it was good he had to follow the advice he gave his patients – drink more water (Pseudo-optimism masking Denial). Later, he developed sleep difficulty, which he attributed to a defective mattress, and again laughed it away. Having always been resilient in life, he felt all would be well with a good exercise and diet schedule (Pseudo-resilience due to Pseudo-optimism. Denial seemed to be at the root – fearing the worst, malignancy or AIDS, and therefore adopting denial).

Till he developed sexual dysfunction. His wife insisted they both underwent a whole body checkup, at which he was found to have a blood sugar of 630 mg/L, with retinal damage having set in.

His physician counselled him the perils of such pseudo-resilience. Dr. G immediately took charge of the situation. One who never took medicines in his life, promptly handed himself over to efficient medication, diet control, exercise, and yoga (Proper Resilience).

His blood sugar was well in control in 3 months, and has so remained since for the last 2 yrs. His retinal damage has been arrested as found at 1 and 2 yr follow-ups.

It is necessary to tease out the 'proper' from 'pseudo-resilience'. While the former is beneficent, the latter is not. Promoting blanket resilience without clarifying which one is proper can be a form of malfeasance.

It is also necessary to avoid 'forced' and 'pseudo' resilience. As also avoid promotion of resilience by pseudo means and the blame game it may give rise

to. For example, the implication that resilience is associated with faster recovery from a disorder could result in blaming patients who don't recover quickly for not trying to be more resilient **(***double effect*). The physician must beware that, in his misplaced benevolent paternalism, he does not harm the patient's self-esteem and damage the very cause he espouses (See Case Vignette 11).

Case Vignette 11: Benevolent Paternalism may amount to Promoting Resilience by Pseudo means

Dr. K is a cheerful gastroenterologist who enthusiastically greets his patients and is aware of the psychosomatics of GIT disorders. Lately he has read about the role of optimism and resilience in getting well. He enthusiastically advises his patients to change for the better, giving examples of how emotions control the GIT e.g. when anxious before an exam/test, some people experience intestinal hurry.

Patients who get well are great ego boosters for the good doctor. However those who do not, remain a challenge he finds difficult to explain. He offers a blanket judgment, blaming them for not being resilient and optimistic enough. He warns them to better change and become more optimistic and resilient in life if they wanted to get well, but does not offer ways to do so (Resilience promotion by pseudo means). He does not hand over his patient to a psychotherapist so that they became more resilient, claiming it was all waste of time, as he was a competent psychotherapist himself, since he kept abreast of psychosomatics.

Such benevolent paternalism may promote resilience by pseudo means.

Dr. K does not realize that having knowledge, and the expertise to implement it, are two different things. His tendency to blame those of his patients who do not recover as not being resilient or optimistic enough is one form of resilience promotion by pseudo means, and amounts to 'harm', albeit unintentionally caused.

While his espousal of resilience is well-intentioned, not implementing it correctly amounts to malfeasance and is an example of 'double-effect'.

4. The Double effects with Social connectivity

Social connectivity is a positive psychosocial factor but it could have unforeseen negative consequences – e.g., blanket promotion of social connectivity may expose some to the perils of being over-social (*double effect*). Some people may be comfortable remaining asocial rather than having a large social network (See Case Vignette 12).

Case Vignette 12: The Perils of Excessive Social Connectivity in the Temperamentally Asocial

Mr. C, 56, is reserved by temperament and has enjoyed good health all through life. He has his small circle of friends with whom he is happy, and enjoys a quiet, contented

life. Six months back, he got to hear of recent findings that greater social connectivity was a positive psychosocial factor and that brain plasticity meant newer neuronal connections could be established at any age. He started socializing with great vigour, stimulating his brain with strenuous cerebral activities like prolonged animated discussions, giving speeches at various functions, continuously interacting on emails in social groups, spending hours on Facebook and Twitter accounts. He started keeping his mobile phone on 24/7 so as not to miss any opportunity to be called over or to interact with new and old acquaintances.

In a few months the whole excitement got the better of him. He started losing sleep. He developed spells of severe headaches with giddiness. He started feeling exhausted most of the times with bouts of irritability over small matters, something that never happened with him before.

He was diagnosed with moderate hypertension.

A man who had lead an otherwise disease free life till a change he forced on himself, got afflicted with a chronic ailment.

His physician started him on anti-hypertensives with only mild improvement. Noting his irritability and lack of sleep, he felt there may be added depression and referred him to a psychiatrist. Here, the patient revealed his changed lifestyle and the reasons. Psychotherapy helped him realize he should lead a more relaxed lifestyle suited to his basic temperament.

Along with medication, he has since reduced his excessive social connectivity and got back to his earlier way of living. His symptoms are much under control.

Social stimulation has its positive effects. But excessive and unregulated social connectivity and stimulation unsuited to basic temperament can be malevolent and have its own negative consequences (*double effect*).

While suggesting the positive effects of these methods, the harm due to its excesses and sudden introduction should be equally emphasized by physicians, especially to those patients who may get carried away otherwise.

Further research into how much and what form of social connectivity and stimulation is useful in which type of person would help preempt chances of such ill-effects. And help reduce the malevolence that can otherwise result.

5. Double effects of Neglecting Cross-cultural Differences

In emphasizing positive psychosocial factors, Positive Psychiatry may neglect important cultural differences and unwittingly coerce homogenization (*double effect*). Eastern cultures seem to stress the role of spirituality more than that of humour, while the reverse may be true for western cultures. Such differences

should not be seen as problematic. The need to understand and judiciously combine such differences in different patients without adopting a straitjacket rule should prevent the informed positive psychiatrist from committing unintended harm (See Case Vignette 13).

Case Vignette 13: Cross Cultural Differences in Coping Mechanisms

Mr. J, a Chinese immigrant to the US, is advised that along with medications for his irritable bowel syndrome, he should be more optimistic and cheerful to cope with his condition. Mr J says he would prefer to take the coping route he knows best as a Chinese – the spiritual route, along with medications.

The US physician should respect his cultural difference and not force humour on him, or deride his dependence on spirituality as a way to cope with his IBS.

There is a risk of creating a homogeneous society where everyone is apparently optimistic, social, etc, but suffering in trying to cope with the forced and sudden changes that over-enthusiastic physicians may force on patients, and often patients may force on themselves due to information bombardment from the internet and other such sources (*double effect***)**. This may be akin to the ill effects of eugenics.

The widely varying tapestry of human beings adds colour and variety to human living. We need optimistic, irreligious socializing people as much as we need religious, asocial, wise beings. Also, human beings have myriad means of coping, and there are different and apparently equally good psychosocial factors. There is no need to unduly promote one over the other till we have scientific evidence either way.

6. Double effects and Unanticipated Long-term Negative Consequences

The further task of finding out the nuances of positive psychosocial factors should occupy researchers in the next decade. Serious researchers should be aware that there can be unanticipated long-term negative consequences of interventions (behavioural or biological) that seek to enhance positive factors (*double effect*). Hence any negative reports on positive factors, and any modifications suggested, should be taken seriously, and not brushed aside as unduly alarmist.

This would the best way beneficence (doing good) would couple with non-malfeasance (do no harm) and prevent avoidable 'double effects'.

7. Autonomy as applied to Positive Psychiatry

Intrinsic to autonomy is the patients' right to refuse or choose his treatment (*Voluntas aegroti suprema lex*.).

How does this apply in Positive Psychiatry?

The evidence for positive psychosocial factors has to be presented to the patient before he is expected to comply with procedures that enhance them, or he modifies his habitual responses (See Case Vignette 14).

Case Vignette 14: How Autonomy works: the Example of two Physicians

Dr. A is a do-gooder who does not believe in presenting evidence before the patient and helping him make his choice. He decides what is best for the patient and will brook no discussion. He uses his physician's position to force patients to select optimism and religiosity as the methods to cope with their disease.

Dr. B presents evidence for various positive psychosocial factors to his patients. He allows them to select what suits them best, discusses various alternatives and helps them arrive at the best methods that suit them, all the time patiently guiding them without allowing them to procrastinate, but also not forcing any methods.

Dr. A's methods do not respect Autonomy. Dr B's methods do. Both are guided by benevolence, but Dr B's is coupled with Autonomy and is therefore more appropriate. Paternalism is no substitute for benevolence.

Moreover, the patient has the right to give or refuse consent to one or more of the procedures the physician/psychiatrist may consider better suited for the patient, except if the patient is legally incompetent. Even if the chances of a legally incompetent person adopting positive measures like optimism, resilience, wisdom are remote, this safeguard is necessary.

The safeguard is also necessary for special populations such as children, older people with mild or major cognitive impairment, people who are otherwise not fully competent to provide consent for treatment, etc. In such cases, legal guardians and health care proxies play a defining role.

8. Justice in general and as applied to Positive Psychiatry

Justice essentially means fairness in procedures adopted, and involves all the other three principles of beneficence, non-malfeasance and autonomy. It is involved at various levels in bioethics. Beneficence is to be adopted, but in a fair manner. Non-malfeasance is to be exercised, but in an equally fair manner. Patient autonomy is to be respected, but in a fair manner. And all this irrespective of sexual orientation/preference, colour, creed, nationality or religion.

What does this entail? [See Case Vignette 15 below].

Case Vignette 15: The Just Physician who respects all aspects of Principlism

Dr. X always keeps himself abreast with the latest developments in his branch and adopts only those evidence based procedures he knows will benefit his patient

[Beneficence]. He will never carry out any procedure which he knows will harm him [Non-malfeasance]. He is careful to explain to his patients the procedure to be carried out without unduly alarming them, even as he informs them fully as to the benefits and risks involved, and carries out procedures only after obtaining a valid consent [Autonomy].

Dr. X offers all this to all his patients, irrespective of their sexual orientation/preference, colour, creed, nationality or religion [Justice].

Dr. X is not only a good physician but also follows the laws of justice. In fact he is a good doctor only because he carries out good procedures in a fair manner.

Justice has further nuances which need elaboration. It essentially means not crossing the border line from beneficence (desirable) to condescending paternalism (not desirable) e.g. doctor decides for patient, brushing aside his objections (see Dr. A in Case Vignette 12; Dr. W in Case Vignette 14(1) below). It also means not being so obsessed with non-malfeasance as to avoid due beneficence e.g. doctor so worried about lawsuits that he does not carry out legitimate treatment e.g. involuntary hospitalization in necessary cases (see Dr. P in Case Vignette 14(2) below). It also means not adopting malfeasance in the garb of beneficence e.g. adopting non-scientific or obsolete procedures in the name of treatment (see Dr. Y in Case Vignette 14(3) below). It also, further, means not giving absolute value to patient autonomy forgetting that such autonomy is relative e.g. not treating a patient incompetent to give consent (see Dr. P in Case Vignette 14(2) below). It also signifies not avoiding desirable beneficence in the name of patient autonomy e.g. covert treatment (see Dr P in Case Vignette 14(2) below).

Justice also means offering all these facilities equally to all patients, irrespective of which creed, culture, sexual orientation or religion/creed they belong to. Discrimination on any count amounts to malfeasance and non-beneficence (see Dr B in case Case Vignette 14(4) below).

Case Vignette 14 below will clarify all this.

Case Vignette 14: The Four Different Physician Errors of Justice

1. *Dr. W is a busy knowledgeable cardiovascular surgeon who likes to take quick decisions for the welfare of the patient. In so doing, he often fails to explain what he intends to do, and also takes for granted that he knows best and patients better comply. He gets a blanket consent form signed by his patients without explaining the process involved. He just pronounces his decisions and his overbearing attitude brooks no refusal, or asking for explanation. If a patient asks for one, he is promptly told to go to another surgeon. Since he is known to be the best with his surgery, the patient meekly acquiesces, even when he is unconvinced about the procedure adopted*

2. *Dr. P is a well-known psychiatrist who refuses to treat involuntary patients because of potential legal hassles. He has heard of such cases happening with colleagues and therefore will just not handle any such patient, even by adopting due legal safeguards like getting consent from health care proxy, or after due certification by the court. He also firmly believes that involuntary treatment is unjust, because it is done against the patient's consent, even if the patient were incompetent to give one. He will also not administer covert treatment, even when he knows the patient has an active psychosis, and is a threat to himself and family if left untreated, and cannot be subjected to involuntary hospitalization or certified by court*
3. *Psychiatrist Dr. Y continues to give insulin coma therapy for his schizophrenic patients and CO_2 narcosis for his neurotic patients as standard procedure, even when he knows these treatments are obsolete*
4. *Psychiatrist Dr. B refuses, or resists, treating transgenders and lesbians because he doesn't like their sexual preferences. He is relieved if such cases do not come back for follow-up. He also has a dislike for those he calls 'communists and atheists'. He enters into prolonged arguments with them in psychotherapy sessions over this almost unwittingly, then regrets it, but repeats it when the patient animatedly defends his position.*

9. How can Justice be of Concern in Positive Psychiatry?

Now where can there be an ethical problem with this concept in the methods of Positive Psychiatry?

The patient's basic introversion and stress induced in him when forced to become social maybe brushed aside by the positive psychiatrist who emphasizes greater social connectivity as an important positive psychosocial method. The patient who may have always adopted 'controlled pessimism' as a coping mechanism which has worked for him, may be forced into optimism, which has not worked for him. He may not be offered the benefits of certain findings like the value of wisdom as a positive psychosocial factor since there are not many studies confirming its value at present. The patient maybe offered homegrown advice or grandma remedies as scientifically validated advice during psychotherapy. The patient may be deprived of the benefits of becoming optimistic, resilient, having greater social connectivity and concentration on pleasant events because the psychiatrist believes he has a poor prognosis psychiatric disorder like schizophrenia with negative symptoms, or early cognitive decline likely to lead to Alzheimer's disease.

The positive psychiatrist may similarly lay undue emphasis on resilience to prevent normal grieving post death of a much loved spouse or post a difficult divorce, both of which take time to resolve. He may encourage the 'patient' to snap out of grief prematurely by adopting 'greater social connectivity'. This may make the patient adopt reckless processes like attending all night parties and entering into one night stands, which carry their own risks of STDs and AIDS, besides rebound grief. The need to explain what type and level of social connectivity is desirable is of the greatest importance.

The psychiatrist/physician may wait indefinitely for fully substantiated evidence of positive psychosocial factors before he inculcates them in his practice. This undue caution is unfair to the patient because it may not allow him to implement known findings, even as he is ready to modify them in the light of any conflicting evidence in the future [See Case Vignette 15].

Case Vignette 15. The Methods of a Good and Just Positive Psychiatrist

Dr. D allows his patients to decide between the methods of positive psychiatry after offering them due information and counsel. He never presents his 'hunches' as scientifically proven, but does present them as 'hunches', for the patient to adopt or reject. He keeps abreast of developments in the field and offers the latest information on positive psychiatry to his patients, irrespective of their race, creed, religion, sexual orientation or socio-economic status. He never forces his personal preferences on his patients, helps them develop their own based on their basic strengths, preferences and shortcomings. He never hustles his patients into deciding this or that process, but does gently prod them forward to take purposive decision on which process to adopt.

Dr. D is not only a good positive psychiatrist, he is also a just one.

Justice demands that patients' autonomy to decide which method to adopt be respected, only scientifically validated advice be given, due discretion be exercised in factors with scarce but emerging evidence, and 'hustling' patient into procedures be avoided. All this needs to be done in a non-discriminatory manner.

As a discerning reader would have realized, a just person is one who embodies a judicious mix of benevolence and non-malfeasance in his actions, with respect for the other's autonomy. In other words, justice embodies the other three biomedical principles. A just person is also one distributes his expertise equally.

10. What if the Values of Principlism are in Conflict?

An understanding based on 'Common morality', 'Particular morality', 'Specification' and 'Balancing' will help here.

Useful rules of thumb are (Singh and Singh, 2009[74]):

1. Beneficence is the bedrock of medicine, Non-malfeasance its conscience, Justice its sentinel, Autonomy its crowning glory (*Common morality*)
2. Each is dynamically linked to the other. But in case of conflict, Autonomy is the first that may need to be compromised, although in very select cases; then Justice, which may be temporarily suspended, although most reluctantly and in the rarest of rare cases. (*Particular morality*)
3. That leaves behind Beneficence and Non-malfeasance. Which is more essential between the two? It is Beneficence. (*Balancing*)
4. Beneficence can never be forsaken. Can Non-malfeasance be forsaken, then?

(*Balancing*). It need not be. If properly implemented, Non-malfeasance is in built in Beneficence

5. In psychiatric *therapy*, Beneficence and Non-malfeasance are paramount, and may occasionally override Autonomy and Justice when they conflict. In psychiatric *research*, however, Autonomy and Justice are paramount, and must always override Beneficence and Non-malfeasance when they conflict (*Specification* and *Balancing*).

From the above discussion, two important principles emerge:

1. Beneficence can never be forsaken (Singh and Singh, 2009[74]) (*Common morality*). Beauchamp and Childress (2009[5]) identify Beneficence as *one* of the core values of healthcare ethics, while Pellegrino and Thomasma (1988[60]) argue that Beneficence is the *sole* fundamental principle of medical ethics. Also, Non-malfeasance is inbuilt in Beneficence (Singh and Singh, 2009[74])
2. Autonomy and Justice may need to be compromised to Beneficence and Non-malfeasance in therapy, although in the rarest of rare cases. But Beneficence and Non-malfeasance need to be always compromised to Autonomy and Justice in research (Singh and Singh, 2009[74])

   It may be noted that Tassano (1995[83]) has questioned the notion of Beneficence having priority over Autonomy at times. He argues that Autonomy violations more often only prioritise the 'State' or the 'supplier group's' interest over those of the patient. There is some merit in that argument, if the 'State' or 'supplier group' is considered *necessarily antagonistic* to the patients' interest. This, however, seems an untenable position, unless of course one lives in a State or society which employs psychiatry for political misuse or to straitjacket dissent. It is true this has happened in the past in certain totalitarian regimes; but to say it is applicable everywhere is to carry the argument a bit far.

   Suffice that for the present. Let us continue with the earlier point.
3. While the first point deals with the primacy of Beneficence and its relation to Non-malfeasance (*Specification*), the second balances the 4 principles in therapy and research and specifies a rule (*Specification and Balancing*).

11. Specification and Balancing of Principlism in the Therapy and Research of Positive Psychiatry

We said earlier that in psychiatric therapy, beneficence and non-malfeasance are paramount, and may very occasionally override autonomy and justice when they conflict. In psychiatric research, however, autonomy and justice are paramount, and must always override beneficence and non-malfeasance when they conflict (Singh and Singh, 2009[74]).

Let us see how this applies to the bioethics of Positive Psychiatry [Case Vignette 16, 17].

Case Vignette 16: The physician's Evidence versus the Patient's Belief system in Therapy: Beneficence and Non-malfeasance occasionally trump Autonomy and Justice

An Indian emigrant to the US, who teaches Indian Philosophy there, develops CVD with depressive symptoms and insists on maintaining a pessimistic outlook to life.

The positive psychiatrist advises that a change of attitude towards optimism would help. He presents data that optimism has been studied in the context of a number of serious medical conditions including cardiovascular disease and shown to be associated with less illness-related distress, higher quality of life and satisfaction, and lower incidence of depression [Carver et al., 2010[11]]. He also presents results from a meta-analysis of 83 studies of optimism which found a significant relationship between optimism and physical health outcomes including cardiovascular outcomes, physiological markers (including immune function), cancer outcomes, outcomes related to pregnancy, physical symptoms, pain, and mortality [Rasmussen et al., 2009[63]].

The patient still insists on continuing with his pessimistic outlook towards life, presenting metaphysical arguments that life is essentially full of suffering (the Buddhist position), and that the world is an illusion [the Advaita Vedanta position on 'maya'].

The physician/psychiatrist had to decide between his duty of beneficence based on scientific findings and the patient's autonomy to continue to hold on to cultural and religious beliefs which appear to hamper his recovery.

What does the physician do?

In ordinary circumstances, the physician should present the scientific findings, and allow the patient's sense of autonomy to decide whether to accept it or not. He should wait for the patient to integrate it with his metaphysical beliefs.

But what if the patient resists this, and his pessimism, according to the physician/psychiatrist, is *mainly* responsible for the lack of recovery? Does he say so directly to the patient? For Beneficence prompts him to do so. Should he decline to continue to treat him, since by allowing the patient to stick to his beliefs, he is causing harm to the patient? (Non-malfeasance)

What about Justice? Being fair to the patient sanctions the patient the right to decide what advice to follow. And therefore to continue to stick to his pessimism. But being just to the patient's interests enjoins upon the psychiatrist/physician to persevere to change the patient's belief on the basis of scientific evidence, especially because it directly impacts the patient's recovery and sense of well being.

Being just to the patient's autonomy, or being just to the physician's beneficence? How do we adjudicate?

Here, the psychiatrist seems well within his duties of Beneficence and Non-Malfeasance to discreetly and cautiously 'override' the patient's autonomy and even the physician's own sense of intuitive justice by ascending in his thinking to a critical ethical level wherein he adjudicates between two or more 'goods' and maximizes utility (Hare, 1984[29]). He would be right to persevere with helping the patient modify his pessimistic outlook to become more optimistic in his attitude towards his ailment, to life and living, so as to recover from his cardiovascular condition; even as he accepts that the patient has the right to hold on to his pessimism as a general metaphysical position and a general rule to make philosophical sense of life and living.

In other words, help the patient adopt optimistic means to aid his recovery, even if the patient continues to retain a generally pessimistic philosophy of life.

Both '*Specification*' and '*Balancing*' are involved here.

In psychiatric therapy, beneficence and non-malfeasance, therefore, are paramount, and may occasionally but most cautiously 'override' autonomy and justice in rare cases when they conflict.

What about the same case in a research setting? Here Autonomy and Justice always trump. See Case Vignette 16.

Case Vignette 16: The Physician's Evidence versus the Patient's Belief system in Research: Autonomy and Justice trump Beneficence and Non-malfeasance

Consider the other case of research. This same patient is a subject of research into the role of optimism in CV cases. The same arguments are presented on both sides. The patient decides to stick to his pessimism and demands that his autonomy be respected. The researcher will present data but stop short of trying to modify his attitude if the patient resists his attempts.

Here the patient's autonomy and justice trump over the psychiatrist's notions of beneficence/non-malfeasance, because as a research subject, the absolute right to accept or reject a certain therapy is with the patient and not with the psychiatrist. In therapy, the patient has the ultimate, but not the absolute, right. The difference between ultimate and absolute must be clarified. Absolute is 'no questions asked'. Ultimate is after all questions are asked/clarified. And also when the person is 'competent' in legal/medical terms to understand what needs to be understood. This maybe especially applicable to small children, those in coma, those having cognitive decline, or those having loss of insight and judgment, say, in chronic schizophrenia.

Such bioethical 'Balancing' will give the much-needed 'Specifications' that correctly guide an ethically sound positive psychiatrist.

Proceeding with Further Discussion

We shall now look at the task for the future, look at some ways to tease out the relative importance, synergy and possible antagonism of various positive psychosocial factors. We shall also scrutinize whether it is necessary to change terminology to reduce baggage. We shall also look at some cautionary statements in the development of Positive Mental Health, which have implications for the development of Positive Psychiatry as well. We shall then look at implications for the future development of the branch, at synergising and integrating with its sister discipline, Positive psychology, and its parent discipline, Positive Mental Health. Finally we shall round up the paper with a discussion of the Aristotelian 4-Causes and its implications for the future development of Positive Psychiatry.

Task for the Future: Seeking Answers to connect/disconnect between Positive Psychosocial Factors

Positive Psychiatry is in its infancy. It has a number of studies to show it holds promise. It has set its background and terrain well in that it will consider all psychosocial factors that make living positive and worthwhile for the psychiatric patient in particular and medical patient in general. And that its research methods will include quantitative data and biology.

However it has a vast area to cover.

It is not enough to just identify positive psychosocial factors like optimism, resilience, self mastery, religiosity, social cooperativeness and support, engagement in pleasant events, wisdom etc. That is necessary but not sufficient. It is necessary to tease out their individual, synergistic and even antagonistic roles.

In other words, we must proceed from 'common morality' to 'particular morality' with 'specification' and 'balancing'.

We will do so by seeking answers to certain hitherto unanswered questions, which must occupy our attention here.

1. Some hitherto answered questions that Positive Psychiatry faces

i. State or trait

Can the positive psychosocial factors be learned, or can they only develop on an existing substratum? How much of it is nature and how much nurture? There is talk of learned optimism (Seligman, 2006[69]), but there is more data needed before the issue is settled about this and other such positive factors.

ii. Does commonplace advice work?

What processes may be enthusiastically applied in the common populace

may require a more restrained application in an ailing populace. How much of resilience, optimism, wisdom, social connectivity will we consider appropriate in patients of psychoses, and in which phase/stage of their restitution? How much of the same in the different neuroses, and personality disorders? For, often, these patients have already been given the common-sense advice by well-wishers to be 'optimistic', 'take adversity in your stride', 'go for a vacation and freak out', 'be in jovial company'. And it has not worked. Often, it is only when they do not work that these patients land up for psychiatric treatment. If the psychiatrist also starts spinning out such common-sense advice, how does the patient benefit?

iii. More in psychosomatic and geriatric population?

Are these factors more important mainly in psychosomatic conditions, and more useful in the geriatric population so as to prolong longevity and lead a more meaningful life inspite of physical and cognitive decline? And so should be studied and applied more there, than in general psychiatric and medical disorders? Even the Case Vignettes presented here and research evidence is mainly related to psychosomatics and the geriatric population.

iv. Choosing between the factors

What is more important, optimism or wisdom? Can there be a general rule, or it will be case to case? If the patient has optimism but no wisdom, how does it impact his recovery and well-being? And vice versa? If he has social connectedness but little resilience, how does it affect his recovery? If he is spiritual but pessimistic, what then?

v. More than one plus, or minus, factor

This is still a simplistic either/or formulation. What about two or more pluses, and equally, of two or more/less minuses? What if a patient is religious, wise, socially connected, but not optimistic or resilient? What if another is resilient and wise but non-spiritual and asocial? What if another still is optimistic and has none of the other positive factors? What if someone is spiritual/religious and again has none of the others? And similarly with social connectedness, wisdom, and the rest?

vi. Hierarchy and connectedness of factors

What is the value we attach to each of these psychosocial factors? Which out of these is of greater importance? Wisdom? Resilience? Optimism? Which is most frequently connected with the other? Are resilient people more optimistic? Is wisdom often connected to self-transcendence? If so, how does it help? If not, then how does it hamper?

vii. Hierarchy of factors (continued)

If a hierarchy of positive psychosocial factors had to be established, where will each of these stand? What if a person has only the top one of those in such a hierarchy? Or the last one in that hierarchy?

viii. Interventions accentuating positive factors

Are these psychosocial factors traits, states, or as we say in a non-committed way, 'factors'? Are there ways available to increase these positive factors, or bring them about in those who lack them? Which interventions do so today, and which will be most suited to do so in the future? Is there the need, and possibility, of a new intervention that will focus of positive factors alone, and bring about well-being? What will be the nature of such an intervention? Psychotherapeutic, psychopharmacological, or both?

ix. Mutually antagonistic psychosocial factors

Is it possible that there may be mutually antagonistic psychosocial factors? That wisdom may correlate more with an asocial attitude that with greater social connectivity? That social connectivity may correlate well with engagement with pleasant activities but may correlate poorly with self-transcendence? And what about synergistic psychosocial factors? Does wisdom synergize with self-transcendence? Does resilience synergize with optimism? Does social connectivity synergize with engagement with pleasant events?

x. Synergistic and antagonistic factors

Is there not a need to further study which are synergistic and which antagonistic positive psychosocial factors?

xi. Genuine and pseudo factors

Are not further studies needed to clarify which are genuine and which 'pseudo' positive psychosocial factors. To clarify between resilience and pseudo-resilience, between optimism and pseudo-optimism, between wisdom and pseudo-wisdom, between spirituality and pseudo-spirituality? Should not this be based of what effect it has on a patient's well-being, not the physician's notions and value-judgments? For example, should we not consider that resilience to be proper which leads to a patient's well-being? And that resilience as pseudo that leads to his ill-health? Should not this be the only consideration to distinguish the genuine from the pseudo?

2. Two further questions, first, philosophical, second, of resource allocation

i. Reductionism versus holism

A further fundamental problem must also engage our attention here. In our preoccupation to establish scientifically verifiable models, is it possible that we are making discrete entities out of those that are integrally and synergistically related to each other, and best understood that way? That these positive psychosocial factors are being artificially separated to suit reductionist scientific convenience of categorizing and standardizing?

ii. Resource allocation

Another issue to be resolved is of resource allocation and the issue of basic expertise. Would it not be appropriate to concentrate scarce resources

on remedies that psychiatrists know best? They are experts in handling psychopathology. That is their expertise and training. There is so much of that to be treated and understood. Is there not a strong case for the argument that the limited resources that exist need to be judiciously harnessed mainly towards the goal of treating and researching psychiatric disorders, rather than foraying into territories best handled by educationists, social thinkers, preachers and religious reformers, who have always talked of the value of wisdom, optimism, resilience, spirituality, self-transcendence, social connectivity and cooperativeness etc?

All these are legitimate unanswered questions which Positive Psychiatry will need to handle in the next decade.

Some other cautionary viewpoints

Some arguments about the concept of Positive Mental Health have been raised by incisive analyses which have implications for Positive Psychiatry. We will take up some of these in this section.

1. Cautions about the mental 'health' concept

Vaillant (2012[91]) lists important cautions about mental 'health', which are equally applicable to Positive Psychiatry. He says: first, in defining mental health, cross-cultural differences must be kept in mind. The second precaution is to keep in mind that 'average' is not healthy. A third precaution is to make clear whether one is discussing trait or state. Finally, mental health needs to be seen in context. Moreover, if mental health is 'good', what is it good for? The self or the society? For 'fitting in' or for creativity?

The same questions can be asked about Positive Psychiatry. In defining its parameters, it must take care of cross-cultural differences, it must keep in mind that average is not healthy, it must specify whether it is considering its attributes as traits or states, and what is the context in which they are applicable. Also, if Positive Psychiatry is good, what is it good for, the self or society, or for both? For fitting in or for a deviance that sets a new trend? These are questions that the emergent branch will have to tackle in the near future.

Further, which mental strengths are associated with mental health is open to debate (Vaillant, 2012[91]). Similarly which positive psychosocial factors are associated with Positive Psychiatry is also open to debate. Optimism, resilience, wisdom seem appropriate. But what about a 'controlled pessimism' which warns of the dangers of unbridled and pseudo-optimism? Or a 'controlled optimism' that is concerned about dangers, but optimistic about final results. Or a 'determination' often bordering on 'stubbornness' while pursuing long-term goals, which may go counter to a common sense idea of resilience? Or

a pragmatism and practical approach which may go counter to usual notions of wisdom and self-transcendence? These are a lot of gray areas which further research should tease out and clarify.

In turn, questions can be raised about Vaillant's seven concepts of Positive Mental Health (Vaillant, 2012[91]): effective functioning, strength of character, maturity, positive emotional balance, socio-emotional intelligence, life satisfaction (true happiness), and resilience.

What is meant by *effective* functioning, what are its parameters, what is effective and what is its difference from ineffective? How do we *quantify* it? What are its neurobiological correlates? What is *strength* of character? The term 'character' carries an enormous baggage. How shall we define strength of character in scientific terms so as to be able to quantitatively study it? What is emotional balance, and what is *positive* emotional balance? When is it achieved, and how, and when lost, temporarily, and permanently? How does it impact well-being, severally and in contrast with other concepts like maturity and effective functioning? What is socio-emotional intelligence, how is it connected with the standard understanding of intelligence we have in psychology? What is *true* happiness? What is happiness itself, and what then is true or false about it?

How do all these seven concepts of Positive Mental Health relate to each other, and as a whole? How do we establish their hierarchy, if at all? Which of these are essential and which minimally contributory to positive mental health? Can the contribution of one of these be significant, although minor? Is the list exhaustive, or is there scope for addition or reduction in their number? How do they stand the 4-principled test of Principlism? And what are their ramifications from the angles of 'common morality', 'particular morality', 'specification' and 'balancing'? And what about their anticipated, and unanticipated, 'double effects'?

All these are unanswered questions which Vaillant and other interested scholars would do well to work over.

Study of prosocial behaviour, 'mirror neurons' and the eight positive emotions of love, hope, joy, forgiveness, compassion, faith, awe and gratitude (Vaillant, 2012[91]; See also Vaillant, 2011[90]) as they impact and modify accepted positive psychosocial factors in Positive Psychiatry enumerated earlier should also be an exciting area of further study. But that is possible only with precise operational definitions and related scientific study rooted in biology and supported by quantitative data.

2. Cross cultural studies

A number of cross-cultural studies are underway in positive psychology to understand which positive psychosocial factors are universal and which variable

amongst different cultures and population. For example, Sheldon *et al.* (2011[75]) found that the psychological 'needs' of autonomy, competence and relatedness predicted positive emotion and life satisfaction to an equal extent within twenty different cultures, including African, Asian, European, Latin, and Australasian cultures. At the same time, the same study also showed that South Koreans reported more relatedness than competence need satisfaction in their 'most satisfying events', while the order was the opposite in the US. Nevertheless, competence and relatedness both predicted positive emotion to the same extent in the two cultures.

Such cross cultural similarities and differences with regard to positive psychosocial factors in Positive Psychiatry will need to be carefully studied as well.

3. Self-directedness, cooperativeness, and self-transcendence

The three 'character traits' of self-directedness, cooperativeness, and self-transcendence that Cloninger (2012[13], 2013[14]) suggests seem to have great merit. How many studies support these concepts? How do we define them for scientific study? Which of them stand in which order of importance if a hierarchy has to be established? What if the self-directed is not self-transcendent? Or lacks cooperativeness? What is the self-transcendent is not self-directed, and only 'selectively' cooperative? Can one be 'selectively' self-directed, cooperative and self-transcendent and yet achieve well-being?

How do Cloninger's concepts of self-directedness, cooperativeness, and self-transcendence gel with other concepts of positive mental health, like the ones Vaillant (2012[91]) mentions? And how do they gel with the other concepts in positive psychology and positive psychiatry we discussed earlier? Can psychiatric patients develop self-directedness, cooperativeness, and self-transcendence? Which of them can, and how? How does such development positively and negatively impact their disorder? Which psychiatric disorders resolve better with which of these character traits? Is there any specificity there, or are these general rules?

All these are also issues for the future to settle.

4. Defining 'positive' and 'health'

The important philosophical issue with the concept of positive mental health Linden (2012[48]) raises is of first defining what we mean by 'positive', and whether 'positive' and 'health' are synonymous. A second question in need of clarification is the relation between health and illness. A third question is which dimensions are included under the term 'health'. One more question is why only psychological constructs are discussed. Are there no biological or somatic dimensions of mental health? Linden (2012[48]) suggests, 'There is no

general definition of illness nor of health which catches all aspects. There are many illnesses, with quite different definitions and criteria, and similarly we should talk about many different forms of health.'

These question can be asked about Positive Psychiatry as well. What do we mean by 'positive' in psychiatry, and whether 'positive' and 'health' are to be considered synonymous? What is psychiatric 'health' and how is it different from psychiatric ill-health? How do positive psychosocial factors maintain psychiatric 'health', or are they only means to reduce psychiatric ill-health? While concentrating on the biological and psychiatric quantitative data, which psychological constructs will also need to be considered, and which not, and why?

5. WHO Well-being Index (WHO-5) and Positive Psychiatry

The WHO (Five) Well-being Index (WHO-5) developed for the purpose of measuring positive mental health (Psychiatric Research Unit, 1998[61]) includes the following five items:

i. Feeling cheerful and in good spirits
ii. Feeling calm and relaxed
iii. Feeling active and vigorous
iv. Waking up feeling fresh and rested; and
v. Having a daily life filled with activities that interest one.

Scoring is from 1-5, and the score is then multiplied by 4 to get a total score. The total score on the WHO-5 ranges from 0 to 100, where higher the score better the well-being. Mean score in the general population is approximately 70, and treatment goal in clinical trials is to move the scores up to that score (Bech, 2012[7]). The predictive validity of the WHO-5 in a 6-year survival analysis of cardiology patients was found to be high (Birket-Smith *et al*., 2009[9]). Also in type 2 diabetic subjects, glycaemic control shows a significant correlation with the well-being index WHO-5, while neuropathic pain was associated with lower well-being score (Papanas *et al*., 2010[59]).

Decreased positive well-being as measured on WHO-5 is a very sensitive, brief screening instrument for depression in primary care (Henkel *et al*., 2003[31]). This scale needs to be used to assess well-being in other psychiatric disorders as well. It is short, easy to use, and a useful clinical barometer to assess psychosocial functioning in research as well as day-to-day clinical practice. Greater work on such easy but useful scales is needed to assess positive parameters of health in psychiatric disorders.

How do the positive psychosocial factors impact these 5 items? Is 'feeling cheerful and in good spirits' correlated with optimism and resilience, and of what type? Is 'feeling calm and relaxed' similarly connected, and how is that related to wisdom and religiosity/spirituality? Is 'feeling active and vigorous' connected to

optimism, and resilience, but not to others? Is 'waking up feeling fresh and rested' similarly connected, and also to wisdom and social connectedness? Is 'having a daily life filled with activities that interest one' mainly related to optimism and social connectedness, but not to others?

Does the WHO-5 Scale essentially measure optimism, resilience and social connectivity while it neglects the other positive psychosocial factors? Is it then still as adequate as a simple tool as it earlier seemed?

6. Some other fundamental unresolved issues

In a short paper, Karlsson (2012[40]) raises a number of pertinent issues related to positive mental health which may have implications for Positive Psychiatry. He thinks one of the main problems in modern psychiatry is the unclearness of diagnostic boundaries, which same issue of unclear boundaries applies also to the entity called positive mental health. He also feels that the difficulty of defining positive mental health is exemplified by the obvious shortcomings of many of the definitions. In these definitions, functioning above normal, the presence of human strengths, positive emotions and subjective well-being are listed as criteria. However, if the basic idea is that positive mental health is more than just the absence of mental illness, it is problematic to say that these features are the core of positive mental health, because the lack of them has a high correlation with mental illness.

Taking a cue from the above, it is better we lay down clear boundaries of Positive Psychiatry, something we did early in the paper. It is also better we define what we mean by Positive Psychiatry so getting into problems with defining 'health' and 'illness' are not unduly paralysing. Something we also did early in this paper.

Karlsson (2012[40]) also takes issue with the concept of 'spirituality' as one component of positive mental health. If equated with religiosity, it would imply that people without religious tendencies couldn't be as mentally healthy as 'spiritual' people. It would also imply that agnostic or atheist people have poorer mental health than 'spiritual' people. He says there is no evidence to substantiate this. However, if a broader definition of spirituality is taken, there are indeed some studies showing that spirituality is associated with mental health. But these modern measures of 'spirituality' actually measure such entities as sense of purpose and meaning in life, social connectedness, optimism, harmony, peacefulness and general well-being (Koenig, 2008[41]; Salander, 2006[65]).

It would be well worth noting whether what we actually consider when we talk of spirituality/religiosity is actually 'sense of purpose and meaning in life, social connectedness, optimism, harmony, peacefulness and general well-being', as Karlsson suggests. A deeper study to tease out its components alone will

furnish this information. And similarly with most other positive psychosocial factors.

Further, Karlsson takes issue with definitions of maturity and socio-emotional intelligence as determinants of positive mental health since such definitions are restricted to the psychological sphere. He emphasizes finding their biological underpinnings. In its case, Positive Psychiatry has taken care of this caution by emphasis on finding neurobiological correlates of psychosocial factors right from the beginning.

Karlsson further raises the issue of real life implementation of core features of positive mental health, which have to get integrally related to where we think society should be headed. He says if we assume that such characteristics as capacity for love, morality, generativity, conflict resolution and negotiation are some of the core features of positive mental health, we should perhaps include in the definition the evidence that these abilities are implemented in real life. We would then have to define positive mental health in terms, for instance, of actions taken towards a society that is more equal and less competitive and exploitative than most current societies are.

This has important implications for Positive Psychiatry. The positive psychosocial factors must be evidenced in real life, and must have a blueprint based on the vision of a final cause. Is it change of societal values that we seek, or the well-being of our patient population? Are they not interconnected? Is patient well-being not dependent on societal values, and will change in societal values not impact patient well-being? And is well-being fundamentally not value-laden and value-driven?

These are bioethical questions that need separate detailed discussion. Suffice it to say here that while the answer to the first question is 'both', the answer to the rest is 'yes'. We will have occasion to discuss some of this as we look into Aristotle's 4-Causes in the last section.

The final caution of Karlsson for further work in positive mental health is equally important here. He says if physical health is ultimately defined in biological terms and if the roots of human mind are in the brain, should not the ultimate definition of positive mental health rely on optimal brain functioning?

What does it imply for Positive Psychiatry? It means that all psychosocial factors must be authenticated by biology, including neurobiology, genetics and epigenetics. This is something that the founding of Positive Psychiatry has already ensured, as we saw earlier in this paper.

7. Positive mental health: contested construct with little data

Another important cautionary viewpoint is of Stein (2012[78]) who makes two important critical observations about positive mental health: one, it remains a fuzzy and contested construct; and, two, there is currently little data on clinician driven positive mental health interventions.

Since we have taken care to lay down the definition of Positive Psychiatry pretty early, and since there is clinical, quantitative and some neurobiological data on psychosocial factors (and where there is none, the emphasis will be on gathering such data), Positive Psychiatry may be said to have preempted Stein's important critical observation.

Further, he notes that while there may be considerable consensus on the beneficial effects of resilience and optimism, there maybe fuzziness when we talk of concepts like 'tuning in to the energies of the universe', that some positive mental health proponents may espouse.

Positive Psychiatry will be able to keep away from such generalities and amorphous statements if it bases its concepts on scientific validation and biological correlation at every stage of its progress. There is nothing wrong with the concept, 'tuning in to the energies of the universe', but for it to be an intervention in Positive Psychiatry, it will need to be precisely defined and scientifically validated, both quantitatively and biologically.

Stein further says there is a dearth of empirical data on the efficacy and cost-effectiveness of positive mental health interventions.

The efficacy criticism does not apply to Positive Psychiatry as there is a reasonable mass of empirical data available, some of which we discussed earlier in this paper. But surely more needs to be done. For cost-effectiveness, we will need further research over time focussing on the cost-effectiveness of individual and collective positive psychosocial factors.

Stein notes further there are many interventions that can potentially help humans to flourish mentally, including education, participation in the arts, etc. Literature in the areas of conceptual work on the meaning of life (Metz, 2007[56]) is growing, as is empirical research on well-being and happiness (Kahneman 2003[38]; Cloninger, 2006[12]; Haidt, 2006[27]). Hence it is debatable whether interventions to improve positive mental health should necessarily fall within the purview of mental health clinicians.

In the case of Positive Psychiatry this objection is again preempted because any 'intervention to help humans flourish mentally' herein has to pass through the process of quantitative studies and biological correlates on patient populations. This makes for least subjectivity and bias, and greatest empirical justification for hypotheses generated.

Stein notes further that while there is universal agreement about the need to treat some typical and burdensome physical and mental disorders, there is less agreement about what constitutes positive mental health, and which clinical interventions may be efficacious and cost-effective.

This has implication for Positive Psychiatry, because what constitutes psychiatric 'health' has still to be precisely defined, as also determining which clinical interventions of Positive Psychiatry will be efficacious and cost effective in which specific conditions. We have pointers but no definitive guidelines still. This is part of the field's agenda for the next decade.

Consensus, definition, scientific validation, biology

The need is to evolve a consensus on what are the valid positive psychosocial factors in Positive Psychiatry, to define them clearly for scientific study, to find their roots in biology and depend on strict scientific verification by quantitative data. To be ready to accept every theory only provisionally and only as long as replicative studies support it, and be ready to modify it on the basis of self-corrections that inevitably keep taking place in science, and even overthrow theories in the light of refutative evidence.

This is the way forward for this nascent branch if it has to ultimately fulfill in the future the promise its initial findings hold in the present.

The bioethical implications of all its findings and interventions need to be carefully studied at each stage so that the 4 principles of beneficence, non-malfeasance, autonomy and justice are never violated, and serve as conscience keepers for the forward growth of this promising branch. For, being an applied science, all further work will be judged on the basis of these four basic questions: (1) does it help the patient? (Beneficence); (2) does it cause minimal hurt and no harm? (Non-malfeasance); (3) does it take into account the valid consent of the patient? (Autonomy); and ultimately, (4) is it fairly distributed to benefit the populace that needs it, and do they have recourse to judicial measures to reconcile any conflict issues that arise between the physician/psychiatrist, the patient and his relatives? (Justice).

All interventions and progress in the branch must stand this litmus test in the thinking of those intimately involved in its propagation, and must be subjected to this test in public from time to time, so there is greater consensus to its forward progress with minimal malevolence.

Defining Terms and Replacing Terms of Common Usage with Technical Ones

It is necessary to debate whether terms of common usage need to be replaced with technical ones. Terms like wisdom, optimism, resilience, spirituality carry

a baggage of centuries of writings and thought of social thinkers, theologists, philosophers etc. While making significant addition to the corpus of knowledge, they have also added to the confusion on the topics by offering many different interpretations that obfuscate issues. For example, there is no one standard definition of wisdom, or of optimism or resilience, which scientific investigation could consider its starting point for further investigation.

Would it not be better for the branch to first offer operational definitions of what it means by terms like optimism, resilience, wisdom etc? That there is first reasonable agreement as to what they mean in scientific terms? *Also whether it makes sense to drop these terms altogether and coin their scientific equivalents?* For example, the way we have terms like *pyrexia* for fever, *ataxia* for loss of coordination, *anorexia* for loss of appetite, *vertigo* for giddiness, *amnesia* for loss of memory etc? This would ensure we get rid of the associated baggage and make the terms sufficiently technical so they can be used primarily in scientific research.

1. Replacing common with technical terms

What does that mean? It means replacing common with technical ones**.** For example, we replace 'optimism' by the Latin '*optimus*'; wisdom by the German '*Weistum*'; resilience by the Latin '*resilire*'; spirituality by the Latin '*spiritualis*', engagement with pleasant events by the Old French '*plaisant*'; self-sufficiency by the Latin '*sufficiens*'; social by the Latin '*socialis*'; social support by the Latin '*supportare*'; subjectivity *by* the French '*subjectivité*', etc. In general use Latin/Greek/French/German equivalents as standard scientific terms before we proceed further with definitions.

Just as quantitative data and biological correlation have been given importance in Positive Psychiatry right from the beginning, replacement of common term with technical terms, which are then precisely defined, will obviate much avoidable confusion later.

2. Replacing 'moral' with 'ethical'

Similarly, the term 'moral' carries a theological baggage which the term 'ethical' doesn't. It may be better to replace the terms 'common morality' with 'common ethics', 'specific morality' with 'specific ethics', 'moral judgements' with 'ethical judgements', 'moral codes' with 'ethical codes', 'moral grounds' with 'ethical grounds' etc. We lay this before the bio-ethical research community for further consideration. It is good that the branch itself is called 'bio-ethics', and not 'bio-morality'. This will, hopefully, help grasp the importance of this point set before them.

Synergizing Positive Psychiatry, Positive Psychology and Positive Mental Health

In synergizing and integrating Positive Psychiatry with its sister discipline, Positive Psychology, and its parent discipline, Positive Mental Health, there is a lot that each can give and take from the other.

Insights and approaches of Positive Psychology will always help broaden Positive Psychiatry's vision and help reduce the psychopathological slant that Psychiatry can never give up, howsoever broad its orientation. Positive Psychology can learn from Positive Psychiatry to add a biological dimension to its quantitative data. The neurobiology of psychosocial factors needs to be delineated not just in the sick but also in the normal population, not just in Psychiatry but also in Psychology. Positive Mental Health can learn from both its progeny to be more scientific and less amorphous with its ideas and its methods. The progeny can learn from the parent never to lose the larger picture – the well-being of human kind as a whole, which the respective branches have the privilege to forward by their respective specialist approaches.

In integrating, it is necessary to know that the branches cannot, and should not, merge. Each carries its special individual expertise, which is best synergized but not synthesized. Also, Positive Mental Health is not just a combination of Positive Psychology and Positive Psychiatry. It is that and something more. It is a movement, a philosophy in action, and therefore necessarily expansive and sometimes amorphous. But it has much to offer in the form of direction and hypotheses which the sister branches can sift and scientifically validate.

It would be prudent each branch knows its strengths and shortcomings and then synergises with the others optimally.

Where is Positive Psychiatry headed and Aristotle's 4-causes

1. Aristotle's 4 Causes formulation

In understanding where this nascent but promising field is headed, and why it is headed there, it would be pertinent to utilise Aristotle's 4-Cause formulation (See his *Physics* II 3 [pg 240-241] and especially his *Metaphysics* V 2 [pg 752, in McKeon, 2001[57]).

Aristotle recognizes 4 Causes that are responsible for all artistic production and human action – Material Cause, Formal Cause, Efficient Cause and Final Cause (See Example 1 below).

Put simply, for any action, there has to be a:

i. Material Cause – 'that from which', means the material from which an entity is made. Aristotle gives the example of bronze for the statue, silver for the saucer etc. *The 'with what' of an entity*
ii. Formal Cause – 'the form or pattern', the account of what is to be. Aristotle gives the example of the ratio 2:1, and the number in general as causes of the octave. *The 'how' of an entity*
iii. Efficient Cause – 'that from which the change or the resting from change first begins'. Aristotle's example is advisor as cause for action, father as cause for

child, in general the maker as a cause of the thing made. *The 'who' of an entity*

iv. Final Cause – 'the end', 'that for the sake of which a thing is', the 'why'. Aristotle gives the example of health as the cause of walking, (why should we walk? To bring about health.). *The 'why' or 'for what' of an entity.*

Example 1: The Case of a Cupboard to explain Aristotelian Causation

Let us take the example of a cupboard to clarify matters. The 'material cause', the 'with what', are the entities from which it is made e.g. the wood, hinges, handles etc. The 'formal cause', the 'how' is the design, made by a designer or whosoever. The 'efficient cause' or 'who' are the carpenter/s and other artisans who make/s it as per design. The 'final cause' or 'why' or 'for what', is the purpose of making the cupboard e.g. to store crockery in the kitchen, display items in the living room, or as a wardrobe in the bedroom.

Primacy is given to the Formal and Final Cause, even whilst not neglecting the Material and Efficient Causes. In other words, the Final Cause - where the cupboard will be placed - is primarily important. Following this a Formal Cause, the design/drawing of the cupboard is made. Following which one decides the material that will be appropriate – wood or steel, the Material Cause – and the artisans who will best execute the work – the Efficient Cause.

2. Applying the Aristotelian 4-Causes to Positive Psychiatry

Apply this concept to Positive Psychiatry.

i. It is firstly important to lay down the Final Cause. '*Why' or 'for what'* Positive Psychiatry? It is to move *beyond,* though not neglect, psychopathology, to achieve better living and well-being *in spite* of psychopathology. To also move beyond a narrow definition of psychiatry as a medical sub-specialty restricted to treatment of psychiatric disorders to a psychiatry of the future which will develop into a core component of the overall health care system, and which, therefore, makes the future of the field brighter and more exciting than ever (Jeste, 2012[34])

ii. What is the Formal Cause, the blueprint on which we base this, the '*how*'? It will be with scientific studies on patients who give valid consent, and always following the 4-principled formulation of Principlism

iii. What is the Efficient Cause, the '*who*'? They are all the psychiatrists and mental health staff, even caring relatives, involved in Positive Psychiatry. *Also the informed and empowered patient as a cause of his own well-being*

iv. What is the Material Cause, the '*with what*'? They are the innumerable patients who will be helped, and have the potential to be equally harmed.

Hence, the processes of the Efficient Cause - the methods of positive psychosocial interventions, need to be carefully researched and used only after confirming their findings based on their neurobiological correlates and scientifically based quantitative studies, and all this after laying down clear

cut operational definitions of standardized terms. In other words, with finding out which methods make some patients with psychopathology do better than others; and applying those methods to help patients do better in spite of their ailment.

For a good cupboard to be made, we need to know 'why' it is being made (here meaning where it has to be placed), then make an appropriate design or 'how' to make it, and employ efficient artisans, or 'with whom' to do so. Similarly, to bring about the best in Positive Psychiatry, we need a clear cut vision 'why' we are doing what we are, a clear cut design on the basis of which we chart our course, and efficient psychiatric services to execute the grand design and achieve the final goal.

3. An important question about processes and patients

The question can be asked here: what about the quality of the material we need to work over? If that material is basically faulty, we may have the best of final goals, the best of designs, the best of artisans, and yet the cupboard will be substandard.

This applies both to (1) The quality of our tools – positive psychosocial interventions; and, to (2) our patients.

Our tools will remain robust if:

a. Our terms are precisely defined with use of technical terms that carry least baggage
b. Our methods are based on the scientific approach of experimental verification by quantitative data and neurobiological correlates
c. There is constant validation by replicative studies; and
d. We accept that all hypotheses, howsoever validated presently, are perennially provisional and refutable.

What about our patients? Are they basically weak material to work over, or rendered weak by the psychomorbidity of their ailments? If this basic material is weak, what is the worth of the best of processes by the best of mental health workers with the best plans for the best ultimate end?

This is a strong argument, to which the clear-cut answer is that it is improper to consider psychiatric patients, or those with a medical condition with psychomorbidity, to be *basically* weak material. They manifest weaknesses because precisely those inner strengths, which can make them strong, have been either weakened by the 'disease', or were never fortified in their handling, either in life, or during their 'sick' phase.

Even the best of wood is strengthened only after it is seasoned. Even the best of steel is weak unless it is tempered. The positive psychosocial factors of

Positive Psychiatry are meant to supply precisely this tempering, this seasoning, to both prevent psychiatric disorders and treat those afflicted with them and with associated physical sicknesses – to 'season' and 'temper' them. The patient will, thus, be a part of both the Material and the Efficient Cause. He will be both the material over which efficient mental health interventions are carried out, and he will be as much a part of the change he needs to bring into himself, empowered as he is by the positive psychosocial interventions he has learnt to perform. The patient then becomes both an *object* and *agent* of change.

What will result thereby is an empowered and seasoned material – a patient population empowered and seasoned by positive psychosocial factors employed by a team of committed mental health workers under a rigorous design of scientifically validated methods of research and interventions. This will help achieve what at present appears an elusive goal – well-being and personal and collective self-actualisation for psychiatric patients. And in so doing, the well-being also all those who treat them. And their branch.

For all medical practitioners, psychiatrists included, actualize themselves through the welfare of their patients, and *only* through them. As do their respective branches.

In achieving the Final Cause of their patients, psychiatrists as though will achieve their own, and their specialty's, Final Cause.

This also is the mission, and challenge, of Positive Psychiatry.

Concluding Remarks

Positive Psychiatry seeks to move beyond a narrow definition of psychiatry as a medical sub-specialty restricted to treatment of psychiatric disorders. It seeks to move to a psychiatry of the future which will develop into a core component of the overall health care system (Jeste, 2012[34]). It has set its foundation well by emphasis on quantitative data and biology. The bioethical implications of findings from Positive Psychiatry and its interventions as an applied science need to be carefully studied at each stage of its development so that the four biomedical principles of beneficence, non-malfeasance, autonomy and justice are never violated, and serve as conscience keepers for the forward growth of this promising branch.

Being an applied science, all further work will be judged on the basis of these four basic questions:

1. Does it help the patient? (Beneficence)
2. Does it cause minimal hurt and no harm? (Non-malfeasance)
3. Does it take into account the valid consent of the patient? (Autonomy); and ultimately

4. Is it fairly distributed to benefit the target populace in a non-discriminatory manner, and have stakeholders recourse to judicial measures to reconcile any conflict issues arising between the physician/psychiatrist, the patient and his relatives? (Justice).

All interventions and progress in the branch must stand this litmus test in the thinking of those intimately involved in its propagation, and must be subjected to this test in public from time to time, so that there is greater consensus over its forward progress with the greatest of beneficence and minimal malfeasance, or autonomy and justice violations.

The further task of finding out the nuances of positive psychosocial factors should occupy researchers in the next decade. Serious researchers should be aware that there could be unanticipated long-term negative consequences of behavioural or biological interventions that seek to enhance positive factors (double effect). Hence any negative reports on positive factors, and any modifications suggested, should be taken seriously, and not brushed aside as unduly alarmist. This would be the best way beneficence (doing good) would couple with non-malfeasance (do no harm) and prevent avoidable 'double effects'.

Positive psychiatry is in its infancy. It has a number of studies to show it holds promise. It has set its background and terrain well in that it will consider all psychosocial factors that make living positive and worthwhile for the psychiatric patient in particular and medical patient in general. And that its methods will be quantitative data and biology.

Positive Psychiatry holds the further promise of making the patient both an object and agent of change.

Take Home Message (See Also Figure 1: Flowchart of the Paper)

1. Positive Psychiatry seeks to move beyond, though not neglect, psychopathology, and to achieve better living and well-being in spite of psychopathology.
2. The four biomedical principles of beneficence, non-malfeasance, autonomy and justice with an understanding of common morality, specific morality, specification, balancing and double effects is important in setting the bioethical agenda of Positive Psychiatry.
3. Beneficence i.e. patient welfare is a key test and Positive Psychiatry passes it due to its emphasis on positive psychosocial factors like resilience, optimism, social connectivity, wisdom, personal mastery, religion/spirituality etc, with interventions based on scientific evidence from quantitative data and biology.
4. However, it must beware of promoting pseudo manifestations of positive psychosocial factors and the potential 'double effects' that can be created thereby (non-malfeasance). It must also be careful not to over-ride patient

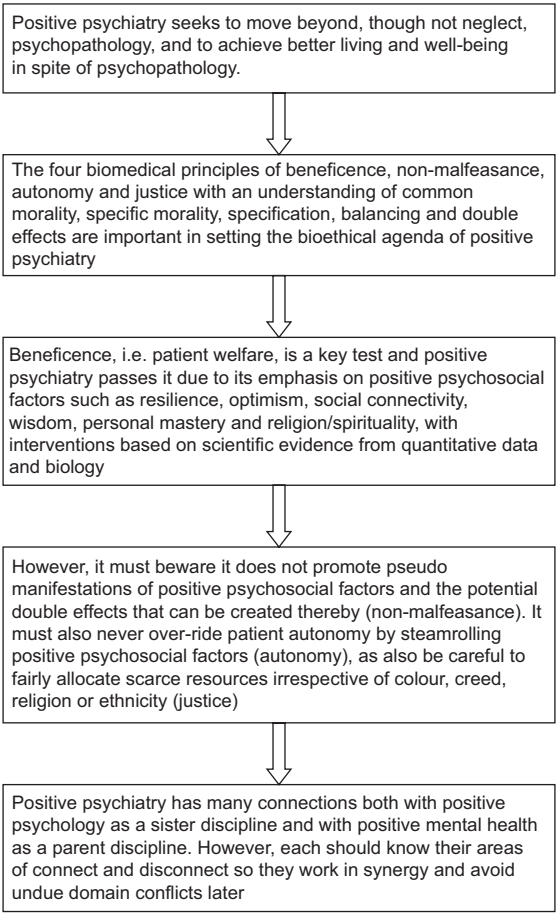

Figure 1: Flowchart of the paper

autonomy by steamrolling positive psychosocial factors (autonomy), as also be careful to fairly allocate scarce resources irrespective of colour, creed, religion or ethnicity (justice).

5. Positive psychiatry has many connections with Positive Psychology as a sister discipline, and with Positive Mental Health as a parent discipline. However each should know their areas of connect and disconnect so they work in synergy and avoid undue domain conflicts later.

Conflict of interest

None declared.

Declaration

Concise version of this paper was published as a Book Chapter called, 'Bioethics of Positive Psychiatry' [Ajai R. Singh, author] in the Book, *Positive Psychiatry: A Clinical Handbook* [Dilip V. Jeste and Barton W. Palmer, eds.], Washington: American Psychiatric Publishing, 2015[37], p325-346]. This is an expanded, peer reviewed and substantially re-written paper. Relevant permission obtained.

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Suggested Reading/Viewing

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Questions that this Paper Raises

1. Can psychiatry afford to allocate scarce resources to the development of a new subspeciality? Should it?

2. Are positive psychosocial factors traits, states, or a mix of both?

3. Should not concepts like resilience, optimism, social connectivity, wisdom, engagement in pleasant events, spirituality etc first be biologically correlated and defined before they become therapeutic tools?

4. Are there perils of adopting straitjacket processes in the name of positive psychosocial factors, and therefore carrying out covert eugenics?

5. It is fine to wish for psychiatry to be a core component of the overall health care delivery system, but for that is it not necessary for psychiatry to set its own house in order by becoming crisp and precise with its diagnostics and its therapeutics?

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