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Chris Peterson's unfinished masterwork: The real mental illnesses

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

Keywords: mental health; character strengths

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

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

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

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

for major depressive disorder to be diagnosed (DSM-4; 2000):

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

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

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

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

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

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

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

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

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

Other labels need more work: For Bravery, its opposite is cowardice, and many of the DSM ‘anxiety’ disorders exemplify cowardice, although overly kind therapists never use this word. Its excess, foolhardiness, also seems right. But its absence is not really captured

by ‘fright.’ For fairness, its opposite, prejudice, seems right, but its absence does not seem to be quite ‘partisanship,’ and its excess is not ‘detachment.’

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

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

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

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

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

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

If we were beginning all over again, how would we choose between the idea of DSM and the idea of the

Table 1. Strengths and virtues.

	Strength	Opposite	Absence	Excess
Wisdom and Knowledge	creativity	triteness	conformity	eccentricity
	curiosity	boredom	disinterest	nosiness
	judgment	gullibility	ineffectiveness	cynicism
	love of learning	orthodoxy	complacency	"know-it-all"-ism
	perspective	foolishness	shallowness	ivory tower
Courage	bravery	cowardice	fright	foolhardiness
	persistence	helplessness	laziness	obsessiveness
	authenticity	deceit	phoniness	righteousness
	vitality	lifelessness	restraint	hyperactivity
Love	intimacy	loneliness	isolation/autism	emotional promiscuity
	kindness	cruelty	indifference	intrusiveness
	social intelligence	self-deception	obtuseness	psychobabbling
Justice	citizenship	narcissism	selfishness	chauvinism
	fairness	prejudice	partisanship	detachment
	leadership	sabotage	compliance	despotism
Temperance	forgiveness	vengefulness	mercilessness	permissiveness
	humility	arrogance	footless self-esteem	self-deprecation
	prudence	recklessness	sensation-seeking	prudishness
	self-regulation	impulsivity	self-indulgence	inhibition
Transcendence	awe	criticism	oblivion	snobbery
	gratitude	entitlement	rudeness	ingratiation
	hope	despair	present orientation	Pollyannaism
	humor	dourness	humorlessness	buffoonery
	spirituality	alienation	anomie	fanaticism

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

Peterson categories have advantages over DSM categories in that

- (1) They are theory based, systematically related to each other; they are not a laundry list of disorders.
- (2) They are defined by universality and so lend themselves to cross-cultural psychopathology.
- (3) They are purer, natural classes.
- (4) They are not tied to a medical model, demanding symptoms, syndrome, and illness.

- (5) They are not reductionistic and do not demand a biological basis as the ultimate criterion of completeness.

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

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

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

These problems have led to an important development in the classification of mental disorders: the Research Domain Criteria (RDoC) initiative of the National Institute of Mental Health. <http://www.nimh.nih.gov/research-priorities/rdoc/nimh-research-domain-criteria-rdoc.shtml> This endeavor seeks to identify converging patterns across genetic, neural, behavioral, and self-report systems. Systematic converging deficits, if discovered, would become criteria of disorders. So, for example loss *might* show a converging pattern of neural, genetic, cellular, and self-reported despair. Such a pattern would then be the criteria of a 'loss disorder.' These newly discovered disorders might or might not map onto DSM disorders. I support such an endeavor; promissory and speculative as it is, because it represents theoretical progress beyond the congeries of symptoms in DSM and it coincides with the recommendations in Forgeard et al. (2012). Such an endeavor – while years to come to fruition if it ever does, would, like the Peterson disorders, constitutes a viable alternative to DSM.

So DSM provided a convenient formula for reimbursement, and a couple of its categories, such as panic disorder and obsessive-compulsive disorder, have behavioral treatments specific to them (Seligman, 2007). Otherwise the treatment implications of DSM have been negligible. One positive to come out of the endeavor, however, is the demand for evidence-based treatment – the increasing demand that treatment be shown to work on the disorder, at least better than placebo. There is a growing list of such evidence-based treatments. But two things must be said: by and large these work only marginally better than plausible placebos for the DSM categories. No magic bullet – or even close – has been discovered for *any* DSM category. Second, finding evidence for treatment efficacy does not depend on the DSM categories, since the very same method – treating a given category with a specific drug or psychotherapy – is just good, tough-minded science and would also need to be done for the Peterson or RDoC disorders.

Finally, are the Peterson pathologies treatable?

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

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

In addition, there is one basic treatment strategy that is highly original to Peterson and cannot be derived from DSM. In addition to the 72 'awry' cells, each of which becomes a target of treatment, there are 24 more cells – the strengths themselves – and there is increasing reason to believe these can be bolstered. These tactics are reviewed strength-by-strength in Peterson and Seligman (2004). Strengthening a strength likely counters the 'absence' of the strength and the 'opposite' of the strength. It is not known if there are parallel tactics for trimming the 'excess' off a strength.

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

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