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

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

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

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

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

Philosophically, apart from the absence of disorder, well-being can be defined either subjectively by the person's own opinion, or normatively by the satisfaction of externally defined criteria. Within economics and politics, there has been a focus on using people's own satisfaction with their lives as a subjective measure of their well-being, most simply by asking, on a 0 to 10 scale, "all things considered, how satisfied are you with your life?". This measure has recently been adopted by the Organisation for Economic Co-operation and Development (OECD)[2] – an intergovernmental organization with 36 member countries - as a core measure of societal performance, health care intervention, and policy. This measure *appears* fair and value free, in that everyone can be measured on the same scale, and people are free to base their answer on whatever parts of their life they value and in whatever way they want to evaluate them. However, A. Sen was awarded Nobel Prize in economics partially for criticisms of the subjective approach. Briefly, Sen highlighted that people living in poverty with ill-health may consider themselves very contented, simply because they are not aware of any alternative[3]. Indeed, they could score higher than a wealthy person in a well-provisioned society. Similarly, people indoctrinated into believing that they are in a good situation (through state propaganda or cult control) may rate themselves

as more satisfied with their life than other people. Subjective evaluations of one's own well-being require information and cognitive abilities; as such, adopting this approach may be particularly problematic when evaluating psychiatric patients.

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

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

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

However, our key point is that the debate must take full consideration of the (often deeply buried and unintuitive) underlying assumptions that are inherent in any definition of well-being, irrespective of whether the account is based on the absence of disorder, subjective, or normative accounts. Further, such a debate must be informed by the discipline of philosophy. Since inception, philosophy has had this very debate on what constitutes well-being (or the "good life") and how it should be practically used. As such, regarding the nature of well-being, only philosophy: Has developed the relevant epistemological tools, has produced most of the vast body of human knowledge on this subject, and still trains professionals specialising in this exact topic. Despite this, other fields have neglected this work and the opportunity for interdisciplinary collaboration. Worse, pop- and armchair conceptions have arisen that imply the field of philosophy is already understood and fully integrated into other fields, discouraging collaboration with or the reading of philosophy. Such neglect has led to lead to approaches already invalidated in philosophy, and causing potential harm when applied. Psychiatry must not make this mistake. As Fava and Guidi point out, the benefit to psychiatry of incorporating the right conceptions of positive well-being are huge. And so are the costs of getting it wrong.

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