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# Lifestyle and Mental Health

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*Mental health professionals have significantly underestimated the importance of lifestyle factors (a) as contributors to and treatments for multiple psychopathologies, (b) for fostering individual and social well-being, and (c) for preserving and optimizing cognitive function. Consequently, therapeutic lifestyle changes (TLCs) are underutilized despite considerable evidence of their effectiveness in both clinical and normal populations. TLCs are sometimes as effective as either psychotherapy or pharmacotherapy and can offer significant therapeutic advantages. Important TLCs include exercise, nutrition and diet, time in nature, relationships, recreation, relaxation and stress management, religious or spiritual involvement, and service to others. This article reviews research on their effects and effectiveness; the principles, advantages, and challenges involved in implementing them; and the forces (economic, institutional, and professional) hindering their use. Where possible, therapeutic recommendations are distilled into easily communicable principles, because such ease of communication strongly influences whether therapists recommend and patients adopt interventions. Finally, the article explores the many implications of contemporary lifestyles and TLCs for individuals, society, and health professionals. In the 21st century, therapeutic lifestyles may need to be a central focus of mental, medical, and public health.*

**Keywords:** lifestyle, therapeutic lifestyle changes, mental health, psychopathology, cognitive capacities

**T**he central thesis of this article is very simple: Health professionals have significantly underestimated the importance of lifestyle for mental health. More specifically, mental health professionals have underestimated the importance of unhealthy lifestyle factors in contributing to multiple psychopathologies, as well as the importance of healthy lifestyles for treating multiple psychopathologies, for fostering psychological and social well-being, and for preserving and optimizing cognitive capacities and neural functions.

Greater awareness of lifestyle factors offers major advantages, yet few health professionals are likely to master the multiple burgeoning literatures. This article therefore reviews research on the effects and effectiveness of eight major therapeutic lifestyle changes (TLCs); the principles, advantages, and challenges involved in implementing them; the factors hindering their use; and the many implications of contemporary lifestyles for both individuals and society.

Lifestyle factors can be potent in determining both physical and mental health. In modern affluent societies,

the diseases exacting the greatest mortality and morbidity—such as cardiovascular disorders, obesity, diabetes, and cancer—are now strongly determined by lifestyle. Differences in just four lifestyle factors—smoking, physical activity, alcohol intake, and diet—exert a major impact on mortality, and “even small differences in lifestyle can make a major difference in health status” (Khaw et al., 2008, p. 376).

TLCs can be potent. They can ameliorate prostate cancer, reverse coronary arteriosclerosis, and be as effective as psychotherapy or medication for treating some depressive disorders (Frattaroli et al., 2008; Pischke, Scherwitz, Weidner & Ornish, 2008; Sidhu, Vandana, & Balon, 2009). Consequently, there is growing awareness that contemporary medicine needs to focus on lifestyle changes for primary prevention, for secondary intervention, and to empower patients’ self-management of their own health.

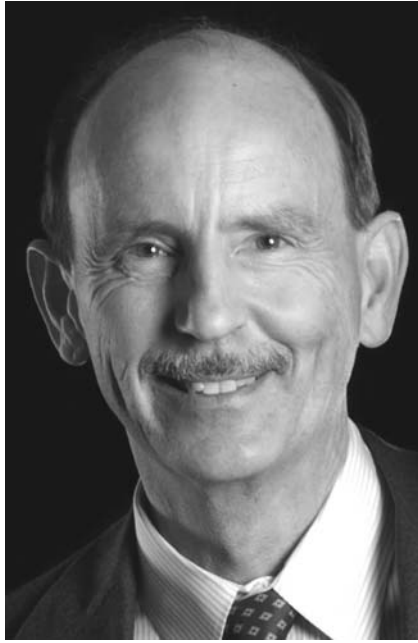
Mental health professionals and their patients have much to gain from similar shifts. Yet TLCs are insufficiently appreciated, taught, or utilized. In fact, in some ways, mental health professionals have moved away from effective lifestyle interventions. Economic and institutional pressures are pushing therapists of all persuasions toward briefer, more stylized interventions. Psychiatrists in particular are being pressured to offer less psychotherapy, prescribe more drugs, and focus on 15-minute “med checks,” a pressure that psychologists who obtain prescription privileges will doubtless also face (Mojtabai & Olfson, 2008). As a result, patients suffer from inattention to complex psychodynamic and social factors, and therapists can suffer painful cognitive dissonance and role strain when they shortchange patients who need more than what is allowed by mandated brief treatments (Luhmann, 2001).

A further cost of current therapeutic trends is the underestimation and underutilization of lifestyle treatments (Angell, 2009) despite considerable evidence of their effectiveness. In fact, the need for lifestyle treatments is growing, because unhealthy behaviors such as overeating and lack of exercise are increasing to such an extent that the World Health Organization (2008, para. 1) warned that “an escalating global epidemic of overweight and obesity—‘globesity’—is taking over many parts of the world” and

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exacting enormous medical, psychological, social, and economic costs.

## **Advantages of Therapeutic Lifestyle Changes**

Lifestyle changes can offer significant therapeutic advantages for patients, therapists, and societies. First, TLCs can be both effective and cost-effective, and some—such as exercise for depression and the use of fish oils to prevent psychosis in high-risk youth—may be as effective as pharmacotherapy or psychotherapy (Amming et al., 2010; Dowd, Vickers, & Krahn, 2004; Sidhu et al., 2009). TLCs can be used alone or adjunctively and are often accessible and affordable; many can be introduced quickly, sometimes even in the first session (McMorris, Tomporowski & Audiffren, 2009).

TLCs have few negatives. Unlike both psychotherapy and pharmacotherapy, they are free of stigma and can even confer social benefits and social esteem (Borfonovi, 2009). In addition, they have fewer side effects and complications than medications (Amming et al., 2010).

TLCs offer significant secondary benefits to patients, such as improvements in physical health, self-esteem, and quality of life (Deslandes et al., 2009). Furthermore, some TLCs—for example, exercise, diet, and meditation—may also be neuroprotective and reduce the risk of subsequent age-related cognitive losses and corresponding neural shrinkage (Hamer & Chida, 2009; Pagnoni & Cekic, 2007; Raji et al., 2010). Many TLCs—such as meditation, relaxation, recreation, and time in nature—are enjoyable and may therefore become healthy self-sustaining habits (Didonna, 2009).

Many TLCs not only reduce psychopathology but can also enhance health and well-being. For example, medita-

tion can be therapeutic for multiple psychological and psychosomatic disorders (Chiesa, 2009; Didonna, 2009; Shapiro & Carlson, 2009). Yet it can also enhance psychological well-being and maturity in normal populations and can be used to cultivate qualities that are of particular value to clinicians, such as calmness, empathy, and self-actualization (Shapiro & Carlson, 2009; Walsh, 2011; Walsh & Shapiro, 2006).

Knowledge of TLCs can benefit clinicians in several ways. Utilizing TLCs may result in greater clinical flexibility and effectiveness and less role strain. It will be particularly interesting to see the extent to which clinicians exposed to information about TLCs adopt healthier lifestyles themselves and, if so, how adopting them affects their professional practice, because there is already evidence that therapists with healthy lifestyles are more likely to suggest lifestyle changes to their patients (McEntee & Halgin, 1996). There are also entrepreneurial opportunities. Clinics are needed that offer systematic lifestyle programs for mental health that are similar to current programs for reversing coronary artery disease (Pischke et al., 2008).

For societies, TLCs may offer significant community and economic advantages. Economic benefits can accrue from reducing the costs of lifestyle-related disorders such as obesity, which alone accounts for over \$100 billion in costs in the United States each year (World Health Organization, 2008). Community benefits can occur both directly through enhanced personal relationships and service (Post, 2007) and indirectly through social networks.

Recent research demonstrates that healthy behaviors and happiness can spread extensively through social networks, even through three degrees of separation to, for example, the friends of one's friends' friends (J. H. Fowler & Christakis, 2008, 2010). Encouraging TLCs in patients may therefore inspire similar healthy behaviors and greater well-being in their families, friends, and co-workers and thereby have far-reaching multiplier effects (Christakis, 2009; J. H. Fowler & Christakis, 2010). These effects offer novel evidence for the public health benefits of mental health interventions in general and of TLCs in particular.

So what lifestyle changes warrant consideration? Considerable research and clinical evidence support the following eight TLCs: exercise, nutrition and diet, time in nature, relationships, recreation, relaxation and stress management, religious and spiritual involvement, and contribution and service to others.

## **Exercise**

Exercise offers physical benefits that extend over multiple body systems. It reduces the risk of multiple disorders, including cancer, and is therapeutic for physical disorders ranging from cardiovascular diseases to diabetes to prostate cancer (Khaw et al., 2008; Ornish et al., 2008). Exercise is also, as the *Harvard Mental Health Letter* ("Therapeutic Effects," 2000, p. 5) concluded, "a healthful, inexpensive, and insufficiently used treatment for a variety of psychiatric disorders."

As with physical effects, exercise offers both preventive and therapeutic psychological benefits. In terms of

prevention, both cross-sectional and prospective studies show that exercise can reduce the risk of depression as well as neurodegenerative disorders such as age-related cognitive decline, Alzheimer's disease, and Parkinson's disease (Hamer & Chida, 2009; Sui et al., 2009). In terms of therapeutic benefits, responsive disorders include depression, anxiety, eating, addictive, and body dysmorphic disorders. Exercise also reduces chronic pain, age-related cognitive decline, the severity of Alzheimer's disease, and some symptoms of schizophrenia (Colcombe & Kramer, 2003; Daley, 2002; Deslandes et al., 2009; Stathopoulou, Powers, Berry, Smits, & Otto, 2006).

The most studied disorder in relation to exercise to date is mild to moderate depression. Cross-sectional, prospective, and meta-analytic studies suggest that exercise is both preventive and therapeutic, and in terms of therapeutic benefits it compares favorably with pharmacotherapy and psychotherapy (Dowd et al., 2004; Sidhu et al., 2009). Both aerobic exercise and nonaerobic weight training are effective for both short-term interventions and long-term maintenance, and there appears to be a dose-response relationship, with higher intensity workouts being more effective. Exercise is a valuable adjunct to pharmacotherapy, and special populations such as postpartum mothers, the elderly, and perhaps children appear to benefit (Hamer & Chida, 2008; Larun, Nordeim, Ekeland, Hagen, & Heian, 2006; Sidhu et al., 2009).

Possible mediating factors that contribute to these antidepressant effects span physiological, psychological, and neural domains. Proposed physiological mediators include changes in serotonin metabolism, improved sleep, as well as endorphin release and consequent "runner's high" (Deslandes et al., 2009; Stathopoulou et al., 2006). Psychological factors include enhanced self-efficacy and self-esteem, interruption of negative thoughts and rumination (Dowd et al., 2004), and perhaps the breakdown of *muscular armor*, the chronic psychosomatic muscle tension patterns that express emotional conflicts and are a focus of somatic therapies (Smith, 2000).

Neural factors are especially intriguing. Exercise increases brain volume (both gray and white matter), vascularization, blood flow, and functional measures (Erickson & Kramer, 2009; Hamer & Chida, 2009). Animal studies suggest that exercise-induced changes in the hippocampus include increased neuronogenesis, synaptogenesis, neuronal preservation, interneuronal connections, and BDNF (brain-derived neurotrophic factor, the same neurotrophic factor that antidepressants upregulate) (Cotman & Berchtold, 2002).

Given these neural effects, it is not surprising that exercise can also confer significant cognitive benefits (McMorris et al., 2009). These range from enhancing academic performance in youth, to aiding stroke recovery, to reducing age-related memory loss and the risk of both Alzheimer's and non-Alzheimer's dementia in the elderly (Hamer & Chida, 2009; Quaney et al., 2009). Multiple studies show that exercise is a valuable therapy for Alzheimer's patients that can improve intellectual capacities, social functions,

emotional states, and caregiver distress (Christofoletti, Oliani, Gobbi, & Stella, 2007; Deslandes et al., 2009).

Meta-analytic studies provide more fine-grained details about the cognitive benefits of exercise for the elderly and offer four kinds of good news. First, the effects can be large, reducing the risk of Alzheimer's disease by 45% and increasing cognitive performance by 0.5 *SD* (Hamer & Chida, 2009). Second, though women may gain more than men, everyone seems to benefit, including both clinical and nonclinical populations. Third, improvements extend over several kinds of psychological functions, ranging from processing speed to executive functions. Fourth, executive functions, such as coordination and planning, appear to benefit most, a welcome finding given that executive functions are so important, and that both they and the brain areas that underlie them are particularly age sensitive (Colcombe & Kramer, 2003; Erickson & Kramer, 2009).

Finally, meta-analyses reveal the specific elements of exercise that benefit cognition. Relatively short programs of one to three months in length offer significant benefits, though programs of six months or longer are more beneficial. There seems to be a threshold effect for session duration, because sessions shorter than 30 minutes—while valuable for physical health—yield minimal cognitive gains. Cognitive benefits are enhanced by more strenuous activity and by combining strength training with aerobics (Colcombe & Kramer, 2003; Hertzog, Kramer, Wilson, & Lindenberger, 2009). In short, research validates the words of the second U.S. president, John Adams, who wrote, "Old minds are like old horses; you must exercise them if you wish to keep them in working order" (Hertzog et al., 2009, p. 26).

Fortunately, even brief counseling can motivate many patients to exercise (Long et al., 1996), and the risks are minimal, although an initial medical exam may be warranted. Yet despite the many mental and medical benefits of exercise, only some 10% of mental health professionals recommend it. And who are these 10%? Not surprisingly, they are likely to exercise themselves (McEntee & Halgin, 1996).

## Nutrition and Diet

There is now considerable evidence of the importance of nutrition for mental health, and an extensive review of over 160 studies suggests that dietary factors are so important that the mental health of nations may be linked to them (Gómez-Pinilla, 2008). Given the enormous literature on this topic, it is easy to feel overwhelmed. Therefore, the following sections review this complex literature but also distill easily communicable principles, because such ease of communication strongly influences whether therapists recommend and patients adopt such treatments (Duncan, Miller, Wampold, & Hubble, 2009). Two major dietary components must be considered: food selection and supplements.

### Food Selection

For food selection, the key principles for TLCs are to emphasize a diet that

1. Consists predominantly of multicolored fruits and vegetables (a “rainbow diet”).
2. Contains some fish (a “pescovegetarian diet”): Preference should be given to cold deep-seawater fish (e.g., salmon), which are high in beneficial omega-3 fish oils, while avoiding the four species with high mercury levels (shark, swordfish, king mackerel, and tilefish) (Oken et al., 2008).
3. Reduces excessive calories: For societies confronting the “globesity” epidemic, reducing excess calories offers both economic and public health benefits (Delpeuch, Marie, Monnier, & Holdsworth, 2009). For individuals, reducing excess calories offers medical and neuroprotective benefits (Prolla & Mattson, 2001). This neuroprotection is especially important in light of recent findings suggesting that adult obesity may be associated with reduced cognitive function, as well as reduced white- and gray-matter brain volume (Raji et al., 2010; Wolf et al., 2007). Fortunately, pescovegetarian diets are low in calories.

Multiple human and animal studies suggest that pescovegetarian diets may prevent or ameliorate psychopathologies across the life span (Gómez-Pinilla, 2008; Willis, Shukitt-Hale, & Joseph, 2009). Such diets may enhance cognitive and academic performance in children as well as ameliorate affective and schizophrenic disorders in adults. They also offer neuroprotective benefits, as demonstrated by reductions in the incidence of age-related cognitive decline, Alzheimer’s disease, and Parkinson’s disease (Gómez-Pinilla, 2008; Kang, Ascherio, & Groodstein, 2005; Morris, Evans, Tangney, Bienias, & Wilson, 2006). Several studies of the Mediterranean diet—including a meta-analysis of 12 prospective studies with over 1.5 million subjects—found reductions in the incidence of both Alzheimer’s and Parkinson’s diseases (Sofi, Cesari, Abbate, Gensini, & Casini, 2008). Dietary elements that appear to be particularly neuroprotective include fish, vegetables, and perhaps fruit, as well as lower intake of animal fats (Gu, Nieves, Stern, Luchsinger, & Scarmeas, 2010; Kang et al., 2005; Morris et al., 2006). Of enormous public health importance are recent findings suggesting that, owing to epigenetic factors, “the effects of diet on mental health can be transmitted across generations” (Gómez-Pinilla, 2008, p. 575).

## Supplements

Growing evidence suggests that food supplements offer valuable prophylactic and therapeutic benefits for mental health. Research is particularly being directed to Vitamin D, folic acid, SAME (S-adenosyl-methionine), and—most of all—fish oil (Sarris, Schoendorfer, & Kavanagh, 2009).

Fish and fish oil are especially important for mental health. They supply essential omega-3 fatty acids, especially EPA (eicosapentaenoic acid) and DHA (docosahexaenoic acid), which are essential to neural function. Systemically, omega-3s are anti-inflammatory, counteract the pro-inflammatory effects of omega-6 fatty acids, and are protective of multiple body systems. Unfortunately, mod-

ern diets are often high in omega-6s and deficient in omega-3s (Freeman et al., 2006).

Is this dietary deficiency associated with psychopathology? Both epidemiological and clinical evidence suggest that it is. Affective disorders have been the ones most closely studied, and epidemiological studies, both within and between countries, suggest that lower fish consumption is associated with significantly, sometimes dramatically, higher prevalence rates of these disorders (Freeman et al., 2006; Noaghiul & Hibbeln, 2003). Likewise, lower omega-3 levels in tissue are correlated with greater symptom severity in both affective and schizophrenic disorders, a finding consistent with emerging evidence that inflammation may play a role in these disorders (Amminger et al., 2010). However, epidemiological studies of dementia and omega-3 fatty acid intake are as yet inconclusive (Freeman et al., 2006).

Epidemiological, cross-sectional, and clinical studies suggest that omega-3 fatty acid supplementation may be therapeutic for several disorders. Again, depression has been the disorder most closely studied (Stahl, Begg, Weisinger, & Sinclair, 2008). Several meta-analyses suggest that supplementation may be effective for unipolar, bipolar, and perinatal depressive disorders as an adjunctive, and perhaps even as a stand-alone, treatment (Appleton, Rogers, & Ness, 2010; Lin & Su, 2007), although at this stage, supplementation is probably best used adjunctively. Questions remain about optimal DHA and EPA doses and ratios, although one meta-analysis found a significant correlation between dose and treatment effect, and a dose of 1,000 mg of EPA daily is often mentioned, which requires several fish oil capsules (Freeman et al., 2006; Kraguljac et al., 2009).

There are also cognitive benefits of supplementation. In infants, both maternal intake and feeding formula supplementation enhance children’s subsequent cognitive performance (Freeman et al., 2006; Gómez-Pinilla, 2008; Innis, 2009). In older adults, fish and fish oil supplements appear to reduce cognitive decline but do not seem effective in treating Alzheimer’s disease (Fotuhi, Mohassel, & Yaffe, 2009).

The evidence on omega-3s for the treatment of other disorders is promising but less conclusive. Supplementation may benefit those with schizophrenia and Huntington’s disease as well as those exhibiting aggression in both normal and prison populations. In children, omega-3s may reduce aggression and symptoms of attention-deficit/hyperactivity disorder (ADHD; Freeman et al., 2006; Song & Zhao, 2007).

A particularly important finding is that fish oils may prevent progression to first episode psychosis in high-risk youth. A randomized, double-blind, placebo-controlled study was conducted of 81 youths between 13 and 25 years of age who had subthreshold psychosis. Administering fish oil with 1.2 g of omega-3s once per day for 12 weeks reduced both positive and negative symptoms as well as the risk of progression to full psychosis. This risk was 27.5% in controls but fell to only 4.9% in treated subjects. Particularly important was the finding that benefits persisted during the nine months of follow-up after treatment cessa-

tion (Amminger et al., 2010). Such persistence has not occurred with antipsychotic medications, which also have significantly more side effects. Although coming from only a single study, these findings suggest another important prophylactic benefit of fish oils.

With one exception, risks of fish oil supplementation at recommended doses are minimal and usually limited to mild gastrointestinal symptoms. The exception occurs in patients on anticoagulants or with bleeding disorders, because fish oils can slow blood clotting. Such patients should therefore be monitored by a physician.

Omega-3s modify genetic expression and as such are early exemplars of a possible new field of “psychonutrigenomics.” Nutrigenomics is an emerging discipline that uses nutrients to modify genetic expression (Gillies, 2007). Because genetic expression is proving more modifiable, and nutrients more psychologically important than previously thought, psychonutrigenomics could become an important field.

Space limitations allow only brief mention of another significant supplement, Vitamin D. Vitamin D is a multipurpose hormone with multiple neural functions, including neurotrophic, antioxidant, and anti-inflammatory effects (Cherniack, Troen, Florez, Roos, & Levis, 2009). Vitamin D deficiency is widespread throughout the population, especially in the elderly, and exacts a significant medical toll; several studies suggest associations with cognitive impairment, depression, bipolar disorder, and schizophrenia. Mental health professionals are therefore beginning to join physicians in recommending routine supplementation (usually 600 units per day) and, where indicated, testing patients’ Vitamin D blood levels and modifying supplement levels accordingly (Cherniack et al., 2009).

There are further benefits to supplementation and pescovegetarian diets. First, they have multiple general health benefits and low side effects. Second, they may ameliorate certain comorbid disorders—such as obesity, diabetes, and cardiovascular complications—that can accompany some mental illnesses and medications. A diet that is good for the brain is good for the body. As such, dietary assessment and recommendations are appropriate and important elements of mental health care.

## Nature

Imagine a therapy that had no known side effects, was readily available, and could improve your cognitive functioning at zero cost. Such a therapy has been known to philosophers, writers, and laypeople alike: interacting with nature. Many have suspected that nature can promote improved cognitive functioning and overall well-being, and these effects have recently been documented. (Berman, Jonides, & Kaplan, 2008, p. 1207)

For thousands of years, wise people have recommended nature as a source of healing and wisdom. Shamans seek wilderness, yogis enter the forest, Christian Fathers retreat to the desert, and American Indians go on nature vision quests. Their experience is that nature heals and calms, removes mental trivia, and reminds one of what really matters (Walsh, 1999). Romantic and existential philoso-

phers echoed similar claims, and the romantic poet William Wordsworth (1807/1998, p. 307) famously described the absence of such a healing connection:

Getting and spending, we lay waste our powers:  
Little we see in Nature that is ours;  
We have given our hearts away . . .

Yet today we are conducting a global experiment in which we increasingly spend our lives in artificial environments—walled inside and divorced from nature. Within these nature-free settings, noise is often annoying, and lighting is often artificial, of low intensity (often less than 10% of the light intensity on sunny days), and composed of nonnatural spectra and rhythms. As the burgeoning field of environmental psychology demonstrates, the psychological costs of such settings can be wide-ranging. These costs include disruptions of mood, sleep, and diurnal rhythms. Cognitive costs include short-term impairment of attention and cognition as well as long-term reduced academic performance in the young and greater cognitive decline in the elderly (Anthes, 2009; Higgins, Hall, Wall, Woolner, & McCaughey, 2005; Küller, Ballal, Laike, Mikellides, & Tonello, 2006). Further psychological difficulties occur in special populations such as those with Alzheimer’s disease and postsurgical patients (Anthes, 2009; Ulrich, 2006).

## Media Immersion and Hyperreality

In the last half century, a further artificial dimension has been added. Increasingly, we now spend hours each day immersed in a flood of multimedia stimuli, the neurological impact of which we are only beginning to understand. However, some researchers have already concluded that “the current explosion of digital technology not only is changing the way we live and communicate but also is rapidly and profoundly changing our brains” (Small & Vorgan, 2008, p. 44). This is hardly surprising given that the average American spends several hours a day watching television and increasing amounts of time with digital media (Putnam, 2000). As Thoreau (1854, p. 85) lamented, people “have become the tools of their tools.”

Fortunately, television and digital media can sometimes be beneficial. Multiple meta-analyses show that although aggressive television content can certainly foster negative attitudes and aggressive behavior, prosocial content can foster positive behavior such as altruism (Mares & Woodard, 2005; Preiss, Gayle, Burrell, Allen & Bryant, 2006). Likewise, digital immersion can benefit certain psychological and social skills in children, as the massive Digital Youth Project demonstrated (Ito et al., 2008).

However, media immersion can also exact significant psychological and physical costs in both children and adults, and a novel vocabulary has emerged to describe multiple “technopathologies.” Excessive media immersion, especially when combined with heavy work demands, can create psychological dysfunctions that include disorders of

- attention: *continuous partial attention* and *attention deficit trait*
- cognition: *digital fog* and *techno-brain burnout*

- overload: *data smog* and *frazzing* (frantic ineffectual multitasking)
- addiction: *screen sucking* and *on-line compulsive disorder*

and, of course, *techno-stress* (Small & Vorgan, 2008; Wehrenberg & Coppersmith, 2008).

Yet the full implications of contemporary media and our divorce from nature may extend much further and cut far deeper than individual stress and pathology. There is an exploding literature on their social effects (e.g., Bracken & Skalski, 2010), and so powerful and pervasive is today's multimedia reality, that for philosophers such as Jean Baudrillard, it constitutes a *hyperreality*—a simulated life-world that seems more real than reality. So omnipresent are media-manufactured images and narratives, and so divorced are we from the direct events they portray, that we largely live in, believe in, and respond to this artificial hyperreal world rather than the natural world itself (Tiffin & Terashima, 2001).

### **Evolutionary, Existential, and Clinical Concerns**

We have barely begun to research the many implications of artificial environments, new media, hyperreality, and our divorce from nature. However, the problems they may pose can be viewed in multiple ways. Biologically, we may be adapted to natural living systems and to seek them out. This is the biophilia hypothesis, and multiple new fields—such as diverse schools of ecology, as well as evolutionary, environmental, and eco-psychologies—argue for an intimate and inescapable link between mental health and the natural environment (Esbjorn-Hargens & Zimmerman, 2009). In existential terms, the concern is that “modern man—by cutting himself off from nature has cut himself off from the roots of his own Being” (Barrett, 1962, p. 126), thereby producing an existential and clinical condition generically described as *nature-deficit disorder* (Louv, 2005).

Clinicians harbor multiple concerns. Evolutionary and developmental perspectives suggest that children in environments far different from the natural settings in which we evolved, and to which we adapted, may suffer developmental disorders, with ADHD being one possible example (Bjorklund & Pellegrini, 2002). Likewise, evolutionary theory and cross-cultural research suggest that for adults, artificial environments and lifestyles may impair mental well-being and also foster or exacerbate psychopathologies such as depression (Buss, 2000).

### **Therapeutic Benefits of Nature**

Fortunately, natural settings can enhance both physical and mental health. In normal populations, these enhancements include greater cognitive, attentional, emotional, spiritual, and subjective well-being (Ho, Payne, Orsega-Smith, & Godby, 2003; Pryor, Townsend, Maller, & Field, 2006). Benefits also occur in special populations such as office workers, immigrants, hospital patients, and prisoners (Maller, Townsend, Pryor, Brown, & St Leger, 2006).

Nature also offers the gift of silence. Modern cities abound in strident sounds and noise pollution, and the days when Henry Thoreau (1849/1921, p. 291) could write of silence as a “universal refuge . . . a balm to our every chagrin” are long gone. Unfortunately, urban noise can exact significant cognitive, emotional, and psychosomatic tolls. These range, for example, from mere annoyance to attentional difficulties, sleep disturbances, and cardiovascular disease in adults and impaired language acquisition in children (Clark & Stansfeld, 2007). By contrast, natural settings offer silence as well as natural sounds and stimuli that attention restoration theory and research suggest are restorative (Berman et al., 2008).

As yet, studies of specific psychotherapeutic benefits are limited, and the benefits are sometimes conflated with those of other therapeutic lifestyle factors. Though further research is clearly needed, immersion in nature does appear to reduce symptoms of stress, depression, and ADHD and to foster community benefits (Taylor & Kuo, 2009; Taylor, Kuo, & Sullivan, 2001). In hospital rooms that offer views of natural settings, patients experience less pain and stress, have better mood and postsurgical outcomes, and are able to leave the hospital sooner (Devlin & Arneill, 2003; Ulrich, 2006). Consequently, nature may be “one of our most vital health resources” (Maller et al., 2006, p. 52). Given the global rush of urbanization and technology, the need for mental health professionals to advocate for time in, and preservation of, natural settings will likely become increasingly important.

### **Relationships**

Of all the means which are procured by wisdom to ensure happiness throughout the whole of life, by far the most important is the acquisition of friends. (Epicurus, quoted in D. Gordon, 1999, p. 35)

The idea that good relationships are central to both physical and mental well-being is an ancient theme, now supported by considerable research. Rich relationships reduce health risks ranging from the common cold to stroke, mortality, and multiple psychopathologies. On the positive side, good relationships are associated with enhanced happiness, quality of life, resilience, cognitive capacity, and perhaps even wisdom (J. H. Fowler & Christakis, 2008; Jetten, Haslam, Haslam, & Branscombe, 2009). Analyses of different domains of life indicate that quality of life is “dominated by the domain of intimacy” and that people with overt psychopathology have a lower quality of life “most particularly in the domain of intimacy” (Cummins, 2005, p. 559).

These clinical observations can now be grounded in the emerging field of social neuroscience, which suggests that we are interdependent creatures, hardwired for empathy and relationship through, for example, the mirror neuron system (Cattaneo & Rizzolatti, 2009). So powerful is interpersonal rapport that couples can mold one another both psychologically and physically. They may even come to look more alike, as resonant emotions sculpt their facial muscles into similar patterns—a process known as the *Michelangelo phenomenon* (Rusbult, Finkel, & Kumashiro, 2009).

Not surprisingly, good relationships are crucial to psychotherapy. Multiple meta-analyses show that they account for approximately one third of outcome variance, significantly more than does the specific type of therapy (Duncan et al., 2009), and that “the therapeutic relationship is the cornerstone” of effective therapy (Norcross, 2009, p. 114). As Irvin Yalom (2002, p. 34) put it, the “paramount task is to build a relationship together that will itself become the agent of change.” Ideally, therapeutic relationships then serve as bridges that enable patients to enhance life relationships with family, friends, and community.

The need may be greater than ever, because social isolation may be increasing and exacting significant individual and social costs. For example, considerable evidence suggests that, compared with Americans in previous decades, Americans today are spending less time with family and friends, have fewer intimate friends and confidants, and are less socially involved in civic groups and communities (McPherson, Smith-Lovin & Brashears, 2006; Putnam, 1995, 2000). However, there is debate over, for example, whether Internet social networking exacerbates or compensates for reduced direct interpersonal contact and over the methodology of some social surveys (Fischer, 2009). Yet there is also widespread agreement that “the health risk of social isolation is comparable to the risks of smoking, high blood pressure and obesity. . . . [while] participation in group life can be like an inoculation against threats to mental and physical health” (Jetten et al., 2009, pp. 29, 33).

Beyond the individual physical and mental health costs of greater social isolation are public health costs. In “perhaps the most discussed social science article of the twentieth century” (Montanye, 2001, para. 1), and in a subsequent widely read book, *Bowling Alone: The Collapse and Revival of American Community*, the political scientist Robert Putnam (1995, 2000) focused on the importance of *social capital*. Social capital is the sum benefit of the community connections and networks that link people and foster, for example, beneficial social engagement, support, trust, and reciprocity (Bhandari & Yasunobu, 2009). Social capital seems positively and partly causally related to a wide range of social health measures—such as reduced poverty, crime, and drug abuse—as well as increased physical and mental health in individuals. Yet considerable evidence suggests that social capital in the United States and other societies may have declined significantly in recent decades (Putnam, 1995, 2000).

In short, relationships are of paramount importance to individual and collective well-being, yet the number and intimacy of relationships seem to be declining. Moreover, “the great majority of individuals seeking therapy have fundamental problems in their relationships” (Yalom, 2002, p. 47). Clients’ relationships are a major focus of, for example, interpersonal and some psychodynamic psychotherapies (Shedler, 2010). Yet clients’ interpersonal relationships often receive insufficient attention in clinical and training settings compared with intrapersonal and pharmacological factors (Pilgrim, Rogers, & Bentall, 2009; Shedler, 2010). Focusing on enhancing the number and quality

of clients’ relationships clearly warrants a central place in mental health care.

## Recreation and Enjoyable Activities

Through experiences of positive emotions people *transform* themselves, becoming more creative, knowledgeable, resilient, socially integrated, and healthy individuals. (Fredrickson, 2002, p. 123)

Involvement in enjoyable activities is central to healthy lifestyles, and the word *recreation* (“re-creation”) summarizes some of the many benefits (Fredrickson, 2002). In behavioral terms, many people in psychological distress suffer from low reinforcement rates, and recreation increases reinforcement. Recreation may overlap with, and therefore confer the benefits of, other TLCs such as exercise, time in nature, and social interaction. Recreation can involve play and playfulness, which appear to reduce defensiveness, enhance well-being, and foster social skills and maturation in children (Lester & Russell, 2008) and perhaps also in adults (G. Gordon & Esbjorn-Hargens, 2007). Recreation can also involve humor, which appears to mitigate stress, enhance mood, support immune function and healing, and serve as a mature defense mechanism (Lefcourt, 2002).

Further recreational activities include art and other aesthetic pleasures, which have long been employed for self-healing. For example, the great 19th-century philosopher John Stuart Mill—one of history’s outstanding intellectual prodigies—spent his childhood force-feeding himself with facts. However, when at 20 he fell into a severe depression, he turned to the arts—music, painting, and especially poetry—for self-therapy, and these, his biographer reported, were what “saved him” (Gopnik, 2008).

Many studies suggest that enjoyable recreational activities, and the positive emotions that ensue, foster multiple psychological and physical benefits (G. Gordon & Esbjorn-Hargens, 2007; Ho et al., 2003; Lester & Russell, 2008). However, some studies of recreation include and conflate additional healthy lifestyle factors such as exercise, relaxation, and time in nature, and there are few clinical guidelines. Mental health professionals will therefore need to use their clinical skills to assess and support individual patients’ interests. “The bottom line message is that we should work to cultivate positive emotions in ourselves and in those around us not just as end states in themselves, but also as a means of achieving psychological growth and improved psychological and physical health over time” (Fredrickson, 2002, p. 120).

## Relaxation and Stress Management

Chronic stressors can exact a major toll across multiple organ systems and levels. This toll extends from psychological to physiological to chemical (e.g., oxidative stress) to genomic expression (hence the new field of psychosocial genomics; Dusek et al., 2008). Even though stress is universal, few people are trained in managing it. In addition, humans now face an array of novel stressors for which there are no evolutionary or historical precedents. Many people therefore respond unskillfully or even self-destructively.

tively, aided and abetted by pervasive unhealthy influences such as advertising, media role models, and novel psychoactive drugs (Buss, 2000). Yet many skillful strategies for stress management are now available, ranging from lifestyle changes to psychotherapy to self-management skills. Beneficial TLCs include almost all those discussed in this article—especially exercise, recreation, relationships, and religious or spiritual involvement—and specific self-management skills can both complement and foster these TLCs.

### **Self-Management Skills**

Specific stress management skills include somatic, psychological, and contemplative approaches. Somatic skills span both ancient Oriental and contemporary Western techniques. The Chinese mindful movement practices of tai chi and qui gong are increasingly popular in the West, and research studies suggest they are associated with both physical and psychological benefits (Kuramoto, 2006). A review of 15 randomized controlled trials of tai chi's effects on psychosocial well-being found significant benefits for the treatment of anxiety and depression but also noted the mixed quality of the trials (Wang et al., 2009).

Western self-management skills include mental approaches such as self-hypnosis and guided imagery (Trakhtenberg, 2008) as well as somatic approaches, especially muscle relaxation therapies that center on systematically tightening and relaxing major muscle groups. By doing this, patients learn to identify and release muscle tension and eventually to self-regulate both muscle and psychological tensions. Muscle relaxation skills are widely used for the treatment of anxiety disorders, including panic and generalized anxiety disorders, and meta-analyses reveal medium to large effect sizes (Manzoni, Pagnini, Castelnuovo, & Molinari, 2008).

Contemplative skills such as meditation and yoga are now practiced by millions of people in the United States and by hundreds of millions worldwide (Walsh, 2011). Concomitantly, an explosion of meditation research has demonstrated a wider array of effects—psychological, therapeutic, neural, physiological, biochemical, and chromosomal—than are associated with any other psychotherapy (Walsh, 2011; Walsh & Shapiro, 2006).

Considerable research suggests that meditation can ameliorate a wide array of (especially stress-related) psychological and psychosomatic disorders in both adults and children (Arias, Steinberg, Banga, & Trestman, 2006; Black, Milam, & Sussman, 2009; Chiesa, 2009; Dusek et al., 2008). Multiple studies, including meta-analyses, show that meditation can reduce stress measures in both clinical and normal populations (Chiesa & Serretti, 2009; Hofmann, Sawyer, Witt, & Oh, 2010). Partially responsive psychosomatic disorders include, for example, cardiovascular hypertension and hypercholesterolemia, hormonal disorders such as primary dysmenorrhea and Type 2 diabetes, asthma, and chronic pain (Anderson, Liu, & Kryscio, 2008; Shapiro & Carlson, 2009). Responsive psychological difficulties include, among others, insomnia, anxiety, depressive, eating, and borderline personality disorders (DiDonna, 2009; Shapiro & Carlson, 2009).

Meditation can also be beneficial when combined with other therapies. The best known combinations are dialectical behavior therapy (primarily used for borderline personality disorder), mindfulness-based stress reduction, and mindfulness-based cognitive therapy. A meta-analysis of mindfulness-based therapies found large effect sizes for anxiety and depressive symptoms of 0.95 and 0.97, respectively, and therapeutic gains were maintained at follow-up (Hofmann et al., 2010).

It is now clear that meditation, either alone or in combination with other therapies, can be beneficial for both normal and multiple clinical populations. However, it is less clear how different meditation practices compare or how meditation compares with other therapies and self-regulation strategies such as relaxation, feedback, and self-hypnosis (Ospina et al., 2007; Walsh & Shapiro, 2006).

Yoga may also be helpful for stress and mood disorders. However, studies on yoga are fewer, and reviews have drawn cautious conclusions (da Silva, Ravindran, & Ravindran, 2009; Kirkwood, Rampes, Tuffrey, Richardson, & Pilkington, 2005; Lipton, 2008; Pilkington, Kirkwood, Rampes, & Richardson, 2005).

In addition to its benefits for relaxation and stress management, meditation may also enhance measures of psychological capacities, health, and maturity in both patients and nonpatients (Walsh & Shapiro, 2006). Particularly important to health care professionals are findings that meditation can enhance valued caregiver qualities such as empathy, sensitivity, emotional stability, and psychological maturity while reducing distress and burnout (Shapiro & Carlson, 2009). On the cognitive side, studies suggest that meditation can enhance some measures of cognition and may reduce age-related cognitive losses and corresponding brain shrinkage (Pagnoni & Cekic, 2007; Xiong & Doraismwamy, 2009). The universality of stress, as well as the multiple benefits of both lifestyle changes and self-regulation skills for managing stress, suggests that these TLCs and self-regulation skills deserve to be central components of health professionals' training, personal and professional practice, and public outreach.

### **Religious and Spiritual Involvement**

Religious and spiritual concerns are vitally important to most people and most patients. Some 90% of the world's population engages in religious or spiritual practices; these practices are a major means of coping with stress and illness; and most patients say that they would welcome their health professionals' inquiring about religious issues (Koenig, 2002). Yet few health professionals do. This lack of attention may be unfortunate given the prevalence and importance of religious and spiritual practices, their many influences on lifestyle and health, their impact on therapeutic relationships and effectiveness, and the deep existential issues they open (J. W. Fowler, 1995; Koenig, 2009).

Considerable research suggests a complex but usually beneficial relationship between religious involvement and mental health. The most massive review to date found statistically significant positive associations in 476 of 724 quantitative studies (Koenig, McCullough, & Larson,



2001). In general, religious or spiritual involvement is most likely to be beneficial when it centers on themes such as love and forgiveness and is likely to be less helpful or even harmful to mental health when themes of punishment and guilt predominate.

Benefits span an array of health measures. Mental health benefits include enhanced psychological, relational, and marital well-being, as well as reduced rates of disorders such as anxiety, depression, substance abuse, and suicide. For physical health, religious involvement seems beneficially related to both specific disorders such as hypertension and to nonspecific mortality rates (Koenig et al., 2001). Strikingly, those who attend religious services at least weekly tend to live approximately *seven years* longer than those who do not, even when factors such as baseline health and health behaviors are statistically controlled (Koenig et al., 2001). Important mediating and contributory factors likely include service to others and especially social support. Contemplative practices such as meditation offer further psychological, somatic, and spiritual benefits (Didonna, 2009; Shapiro & Carlson, 2009; Walsh & Shapiro, 2006).

### **Religion, Spirituality, and Psychological Development**

It is important for mental health professionals to recognize that there are multiple levels of religious development. These levels range from *preconventional* to *conventional* to *postconventional* (or from *prepersonal* to *personal* to *transpersonal*) and are associated with extremely different kinds of religious faith, practice, behavior, and institutions (J. W. Fowler, 1995; Wilber, 2005, 2006).

For example, consider the developmental stages of religious faith. At the preconventional level, mythic-literal faith involves an unreflective, literal acceptance of culturally provided beliefs. At the synthetic-conventional level, people begin to create their own individual, but still largely unreflective, synthesis of diverse conventional beliefs. At later postconventional stages, exemplified by conjunctive and universalizing faith, individuals critically reflect on conventional assumptions, open themselves to multiple perspectives, confront paradoxes, and extend their care and concern to all peoples (J. W. Fowler, 1995; Wilber, 2006).

When developmental differences go unrecognized, problems ensue. For example, the views of one level are taken as normative, and those at this level tend to assume that people at other levels are mistaken, misguided, malevolent, or disturbed (Wilber, 2005). Many contemporary religious and cultural conflicts appear to reflect these kinds of cross-level misunderstandings (Walsh, 2009).

This developmental perspective brings new clarity to many religious and spiritual issues. For example, it makes clear that religions are not only culturally diverse but also developmentally diverse, and that mental health professionals need to be sensitive to both kinds of diversity. Religion can be an expression of immaturity, conventional maturity, and postconventional maturity, and of corresponding motives and concerns ranging from egocentric to ethnocentric to worldcentric (Wilber, 2006). Interpretations

that view religion as, for example, always regressive or always transcendental invariably overlook this developmental perspective. Examples of reductionistic interpretations that view religion as *necessarily* regressive or pathological include the writings of the so called “neotheists,” such as the recent extremely popular books *The God Delusion* (Dawkins, 2006), *The End of Faith* (Harris, 2005), and *God Is Not Great* (Hitchens, 2007), all of which are ignorant of developmental research. Unfortunately, the widespread failure to recognize developmental differences—in faith, morality, values, ego, worldview, and more—and their far-reaching implications for religion and multiple other areas of life seems a significant factor underlying many contemporary cultural conflicts (Walsh, 2009; Wilber, 2006).

Of course, religious behavior can sometimes be regressive or pathological. However, religious behavior can also both express and foster healthy, mature, and even exceptionally mature development. In fact, a classic goal of spiritual practices such as meditation is to foster postconventional development through, for example, *bhavana* (mental cultivation) in Buddhism and *lien-hsin* (refining the mind) in Taoism (Walsh & Shapiro, 2006). Contemporary research and meta-analysis are supportive, because meditators tend to score higher on measures of ego, moral, and cognitive development as well as self-actualization, coping skills and defenses, and states and stages of consciousness (Alexander & Langer, 1990; Alexander, Rainforth, & Gelderloos, 1991). Ideally, religious and spiritual traditions offer both *legitimacy* (support for people’s current level of psychological and faith development) as well as *authenticity* (support for maturation beyond current levels) (Wilber, 2005). Given the significance of religious and spiritual involvement, it seems important for therapists to be familiar with developmental and other key issues and, where appropriate, to inquire about and support healthy involvement in this domain.

### **Contribution and Service**

From ancient times, service and contribution to others have been regarded as virtues that can benefit both giver and receiver (Walsh, 1999). The world’s major spiritual traditions emphasize that, when viewed correctly, service is not necessarily a sacrifice but rather can foster qualities that serve the giver—such as happiness, mental health, and spiritual maturity. Altruism is said to reduce unhealthy mental qualities such as greed, jealousy, and egocentricity while enhancing healthy qualities such as love, joy, and generosity (Hopkins, 2001; Walsh, 1999). The benefits of service are also said to extend to healing, such that healing oneself and others can be intimately linked. Multiple myths and healing traditions describe *wounded healers*, people who by virtue of their own illness learn to heal others and may thereby be healed themselves.

In our own time, both theory and research point to correlations between altruism and measures of psychological and physical health. Multiple studies, including those that control for prior health factors, suggest that people who volunteer more are psychologically happier and

healthier, are physically healthier, and may even live longer (Borgonovi, 2009; Grimm, Spring, & Dietz, 2007; Post, 2007). The so-called “paradox of happiness” is that spending one’s time and resources on others can make one happier (Walsh, 1999).

Altruists of all ages may experience a “helpers’ high” (Post, Underwood, Schloss, & Hulbert, 2002). Even required community service for adolescents seems to effect long-term positive psychological changes, and even mandated monetary donations can make college students happier than spending the money on themselves (Dunn, Aknin, & Norton, 2008). Erik Erikson (1959) famously suggested that “generativity” (care and concern for others, and especially for future generations) may be a hallmark of successful maturation. Moreover, altruism has a positive social contagion or multiplier effect. For example, cooperative behaviors cascade through social networks to induce further cooperation in others (J. H. Fowler & Christakis, 2010), and at the community level, service is a key contributor to social capital (Putnam, 2000).

In summary, considerable research shows positive relationships between altruistic behavior and multiple measures of psychological, physical, and social well-being. However, there are important qualifiers. Major exceptions include the caretaker burnout experienced by overwhelmed family members caring for a demented spouse or parent. Furthermore, the kind of motivation powering the prosocial behavior affects outcome. Whereas service motivated by pleasure in helping is associated with multiple positive measures (such as positive affect, self-esteem, self-actualization, and life satisfaction), this association may not hold when service is driven by a sense of internal pressure, duty, and obligation (Gebauer, Riketta, Broemer, & Mai, 2008).

Psychotherapists repeatedly rediscover the healing potentials of altruistic behavior for both their patients and themselves. Alfred Adler emphasized the benefits of “social interest,” and helping other group members contributes to the effectiveness of group therapy and support groups such as Alcoholics Anonymous (Duncan et al., 2009). Likewise, therapists often report that helping their patients can enhance their own well-being (Yalom, 2002). Wisely perceived, altruism is not self-sacrifice but rather enlightened self-interest (Walsh, 1999). As the Dalai Lama put it, “If you’re going to be selfish, be wisely selfish—which means to love and serve others, since love and service to others bring rewards to oneself that otherwise would be unachievable” (quoted in Hopkins, 2001, p. 150).

These benefits of altruism hold major implications for our understanding of health, lifestyle, and therapy. On the basis of their research findings, Brown, Nesse, Vinokur, and Smith (2003) wrote an article titled “Providing Social Support May Be More Beneficial Than Receiving It” and concluded that interventions “designed to help people feel supported may need to be redesigned so that the emphasis is on what people do to help others” (p. 326). Other researchers quipped, “If giving weren’t free, pharmaceutical companies could herald the discoveries of a stupendous new drug called ‘Give Back’—instead of ‘Prozac’” (Post & Niemark, 2007, p. 7). Contribution and service to others

have long been considered central elements of a life well lived. Now they can also be considered central elements of a healthy life.

## Discussion

A culture’s technology has far-reaching effects on people’s psychology and lifestyles (Wilber, 2000), and modern technology is now affecting our psychology, biology, society, and lifestyles in ways we are only beginning to comprehend. Moreover, technological innovations and their lifestyle effects are changing “more quickly than we know how to change ourselves” (Putnam, 2000, p. 402). Many of the resultant costs are doubtless as yet unrecognized, and this raises a disconcerting question: Could some of our patients be “canaries in the coal mine,” warning us of ways of life that may exact a toll on us all? This is a question that health professionals will need to confront increasingly as technological, environmental, and lifestyle changes accelerate.

### **Interactions Among Therapeutic Lifestyle Factors**

Fortunately, individual TLCs appear to counter many medical and psychological complications of contemporary pathogenic lifestyles. This raises a hopeful possibility: Might multiple TLCs be even more effective? There is evidence for this possibility in both animal studies and clinical medicine. For example, physical activity increases neuronogenesis in the rat hippocampus. However, the effect is maximal only when the animals are exposed to a rich social environment rather than living in isolation (Stranahan, Khalil, & Gould, 2006). Similarly, in his program to reverse coronary arteriosclerosis, Dean Ornish employed four TLCs—exercise, vegetarian diet, relaxation and stress management, and social support. Each proved beneficial, and the effects were additive (Pischke et al., 2008). Might this also be true for psychological disorders? Quite possibly, but as yet we have no clear answer.

### **Difficulties of Implementing Therapeutic Lifestyle Changes**

Given the many advantages of TLCs, why have mental health professionals been so slow to adopt them? The reasons involve patients, therapists, and society. Effective public health programs will therefore need to address all of them.

For patients, TLCs can require considerable and sustained effort, and many patients feel unable or unwilling to tackle them. Patients often have little social support, little understanding of causal lifestyle factors, and a passive expectation that healing comes from an outside authority or a pill (Duncan et al., 2009). Societally, whole industries are geared toward encouraging unhealthy choices. Patients contend with a daily barrage of psychologically sophisticated advertisements encouraging them, for example, to consume alcohol, nicotine, and fast food in the never-ending search for what the food industry calls the “bliss point” of “eatertainment” through “hypereating” (Kessler,

2009). Unfortunately, one can never get enough of what one does not really want, but one can certainly ruin one's health and life trying (Walsh, 1999).

Therapists also face challenges. The first is simply to become familiar with the large literature on TLCs. The second is a professional bias toward pharmacological and formal psychotherapeutic interventions. In addition, fostering patients' TLCs can be time intensive, can demand considerable therapeutic skill, and is not well reimbursed. Therapists may also harbor negative expectations (not without some justification) that patients will not maintain the necessary changes. However, it is crucial to be aware of the Rosenthal effect: the self-fulfilling power of interpersonal expectations. Finally, cognitive dissonance may be at work when therapists' own lifestyles are unhealthy (McEntee & Halgin, 1996).

Taken together, these therapist beliefs and biases may constitute a variant of what is called *professional deformation*. This is a harmful distortion of psychological processes such as cognition and perception that is produced by professional practice and pressures. As long ago as 1915, a sociologist observed that "the continued performance of a certain profession or trade creates in the individual a deformation of the reasoning process. . . . such deformation is largely a matter of adaptation to environment" (Langerock, 1915). Professional deformation can be extreme. Consider, for example, the forced psychiatric hospitalization and drugging of Soviet dissidents by Soviet mental health professionals who believed that the counterconventional beliefs of these "patients" were diagnostic of "sluggish schizophrenia" (van Voren, 2002).

However, more subtle forms of professional deformation may be more pervasive and more difficult to recognize. The mental health system's current pharmacological emphasis—at the cost of psychotherapeutic, social, and TLC interventions—may be one example. This pharmacological bias is heavily promoted by the pharmaceutical industry, and Marcia Angell, former editor of the *New England Journal of Medicine*, concluded that "one result of the intensive bias is that . . . even when changes in lifestyle would be more effective, doctors and their patients often believe that for every ailment and discontent there is a drug" (Angell, 2009, p. 12). An obvious question then becomes: Does the widespread underemphasis on lifestyle factors across mental health professions constitute a further example of professional deformation?

Are there additional therapeutic lifestyle factors? Certainly, and examples range from sleep hygiene to ethics, community engagement, and the moderating of television viewing, all of which have demonstrated mental health benefits (Ito et al., 2008; Preiss et al., 2006; Putnam, 2000; Walsh, 1999).

Wide-scale adoption of TLCs will likely require wide-scale interventions that encompass educational, mental health, and public health systems. Political interventions may also be necessary, for example, to reduce children's exposure to media violence and unhealthy food advertising. Of course, these are major requirements. However, given the enormous mental, physical, social, and economic costs

of contemporary lifestyles, such interventions may be essential. In the 21st century, therapeutic lifestyles may need to be a central focus of mental, medical, and public health.

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