

## Chapter 11. Expanded Dysthymia

### Major Points

- **Over 50% of the population may be mildly depressed (expanded dysthymic) in that their quality of life could be made higher—possibly dramatically higher—by The Adjustment, allowing them to live up to their full potential.**
- **Describes the relationship between expanded dysthymia and ‘searching’ (i.e., continuously altering one’s lifestyle to find contentedness), of which high achievement is a special case.**
- **Draws an analogy between poor vision (sightedness) and expanded dysthymia, both of which affect complex organs—the eye and the brain—and both of which are very common.**

Here I am expanding the concept of dysthymia, or mild long-term depression, to include a much broader array of individuals who generally haven’t been considered to have anything wrong with them, but nonetheless have non-optimal Big Three strengths. Expanded dysthymia may also include many or all people with overt mental illnesses. The term is somewhat misleading because it refers here to more than just mood, but then again depression is known to affect Big Three traits other than just mood. I’m not suggesting that everyone with expanded dysthymia has an overt mental illness, just that their quality of life is not as high as it could be.

Expanded dysthymia results when any one of the Big Three—especially ser or nore—is too strong or too weak, and is worse if more than one of them is too strong or too weak. The further from optimal Big Three strengths a person is, the greater the magnitude of the dysthymia. So we can think of the expanded dysthymia circuits as a logical NOT for ser and nore (see Chapter 6), in that ser and nore are not both at mid-range, optimal strengths. One extreme possibility is that nearly 100% of the population is expanded dysthymic; another extreme is that fewer than 10% are—which is even lower than the percent diagnosed with overt mental illnesses in their lifetime. My estimate is that it includes over 50% of the population. And it is possible that, in spite of the potential side effects of existing Big Three drugs, over 50% of the population would experience higher quality of life if The Adjustment were performed properly on them with these drugs. Based on Big Three personality traits that I have observed, most expanded dysthymics have weak ser and/or strong nore; in fact, most of the population has weak ser and/or strong nore. Strong nore or strong ser are two special cases of expanded dysthymic types, and are perhaps the dysthymic types most likely to exhibit dominance (see Chapter 13).

There’s a tendency to think that ‘normal’ or at least ‘average’ is bad, but maybe having average (optimal, mid-range) ser and nore strengths is amazing, though this may actually be quite uncommon. All people who have or previously had the overt mental illnesses previously mentioned may qualify as expanded dysthymic also, though not all dysthymics exhibit overt, *DSM-IV-TR* diagnosable mental illnesses. Ratey and Johnson

(*Shadow Syndromes*) and Kramer (*Listening to Prozac*) point out that there exist so-called forme fruste disorders characterized by a few, possibly subtle versions of the symptoms—or perhaps no overt symptoms—of the full-blown mental illness. My point is that for expanded dysthymia a person can have *zero* conventional mental illness symptoms.

When The Adjustment works and corrects expanded dysthymia, I'm guessing it beats money, fame, power, prestige, or any combination thereof. If most dysthymics knew what they were missing, they'd be willing to fight for the treatment. A widespread belief is that there is no response to antidepressants unless someone is depressed, or more generally it is widely believed that there is no response to Big Three drugs unless someone is overtly mentally ill. I disagree: there is always a response when the Big Three are altered, including in the correction of expanded dysthymia.

### **High Achievement and Searching**

The current theory hypothesizes that expanded dysthymia is so common because it motivates one to achieve, due to dissatisfaction with what one has. So an intraspecies (within the human race) evolutionary 'arms race' may have selected for high achievement, and therefore selected for large numbers of dysthymics. In this scenario, high achievement was selected for by evolution for at least two reasons: because the high achiever tends to possess both higher social status and greater physical resources such as possessions, leading to greater reproductive success. Perhaps the advent of civilization and living in very large groups intensified the arms race. In addition, human migration about the globe in the last 100,000 years may have selected for dysthymia to drive that migration—those who were happy got left behind. In other words, perhaps the human race used to be happier. So evolution cast us into this world, but only made some of us half-alive, since evolution does not practice utilitarianism—which is the principle of producing the greatest good for the greatest number of people—or even at all produce similar quality of life among different individuals. Some of us have wonderful lives, and others have miserable lives. So it can be viewed as an evolutionary engineering flaw, or consequence, that many of us have Big Three abnormalities. In summary, mental pathology, though not necessary for high achievement, often drives it.

If expanded dysthymia and high achievement are closely related, then maybe megalomania—which is a preoccupation with grandiose or extravagant things or actions—is the thought process that drives high achievement, because the person doesn't have normal emotional responses to normal stimuli. Perhaps necessary for megalomania: weak or nonexistent emotional responses to normal stimuli. A related idea is that if emotions are maxed out or very strong to normal stimuli, then seeking greater stimuli is unlikely. In other words, if a person has robust emotional responses to small stimuli that saturate at a certain point that is no lower than that which is evoked by large stimuli, they would have no motivation other than reason to pursue megalomaniacal goals. Megalomania may be more common in men than in women, and American culture may encourage it, for better or for worse. Along these lines, is expanded dysthymia overrepresented in the United States, due to dysthymic immigration? Not only does the United States attract high achievers, but also the culture reinforces this behavior. It would be interesting to compare the prevalence of expanded dysthymia in different countries. Maybe expanded dysthymia is also overrepresented among academics—a type of high

achiever—versus the general population. I think being super strong in one or more of the Big Three—where being super strong produces subtypes of expanded dysthymia—makes high achievement more likely, because this indicates dominance. However, dysthymia in and of itself may produce a type of dominance (see Chapter 13).

If many expanded dysthymics are workaholics, they probably act this way because for them, the rewards of working may be about as good as life gets. So dysthymia may drive high achievement in part by ‘keeping the feet to the fire’, with the dysthymic person feeling compelled to work super hard. On the other hand, some dysthymics seem to have lower than average ambition.

Expanded dysthymia could drive high achievement but so could euthymia or a strong brain reward system—they both can and probably do. So even without dysthymia it would probably still be human nature to strive for something better, to be ambitious.

There may also be a fine line between high achievement and no achievement. In other words, paradoxically, as dysthymia increases among different people, high achievement can increase while ability to function decreases—cases in point: famous artists, certain politicians and leaders such as Abraham Lincoln, certain businessmen such as Howard Hughes. If expanded dysthymia turns out to affect most of the population, including all socioeconomic groups, and we medicated nearly every one of these people and wiped out most of the dysthymia, we may then be less ambitious as a society—perhaps at this point in history that may not be such a bad thing. I think most individuals within the population should be similarly dysfunctional in Big Three abnormalities. So maybe many people are dysthymic enough that they barely function, but not more so, producing high ambition.

If *super* non-optimality of ser and nore produce low achievement, since the person is not able to function, perhaps the graph of achievement versus ser and/or nore optimality has an inverted U-shaped curve (see Figure 3), with somewhat of a non-optimality producing highest achievement. Such a curve would also predict the existence of pairs of data points—the intersections of horizontal lines—for which achievement is the same but the member of the pair with greater non-optimality has a lower quality of life than the other member. If one can get equivalent performance or achievement with greater quality of life, then one should always choose greater quality of life.

Perhaps high achievement is actually a special case of ‘searching’ caused by expanded dysthymia. Searching, or more specifically high achievement, does not always follow from dysthymia, but dysthymia perhaps makes it more likely. Searching means that one is continuously altering one’s lifestyle—significant other, job, hobbies, place of residence, etc.—to find contentedness, which one never quite achieves. Like the special case of high achievement, searching may have been selected for by evolution because it led to greater reproductive success. Dysthymia may drive searching but do other mild forms of mental illness?

The thought process that may accompany searching is what I call ‘false attribution’. This means blaming the way the world is—or at least one’s situation in the world—for one’s unhappiness instead of blaming one’s own brain. Along these lines, some people think that the current modern environment is at least partly responsible for making them unhappy. I take a more cynical stance: they would have been just as unhappy (dysthymic) if they had lived prior to civilization.

A concept related to searching is what I term ‘the stationary test’, which consists of asking whether one can remain content or even function without frequently having major changes in one’s lifestyle. This test can be thought of as pass/fail, or instead one can think of it as having intermediate answers, such as that one is able to function *somewhat* without major changes in lifestyle.

Searching may not in all cases be caused by expanded dysthymia, since psychological environmental adaptation, in other words burnout or situational depression, may be another cause, and such adaptation may be more intense for people with strong dop, as in Cloninger’s ‘novelty seeking’ dop trait, discussed in the next chapter. But whether due to expanded dysthymia or strong dop adaptation, the constant or at least recurrent need for fundamental changes in one’s lifestyle may reflect underlying Big Three strength pathology.

### **Relationship to Dominance**

In people with expanded dysthymia, the brain may in some ways be shut down. Shutting down of the brain—or deadening of Big Three traits, see Chapter 7—due to Big Three strength abnormalities, is closely related to shutting down of the brain with dominance (see Chapter 13). More generally, quality of life is not just a matter of mood, but also how the brain responds to the world, and this is affected by Big Three functional traits.

The ways in which different expanded dysthymics perceive the world probably vary greatly, though all or nearly all dysthymics may have one trait in common: lack of, or at least diminished, positive perception of and reaction to the world. Maybe deadening of mood and positive emotional responses—‘the glow goes away’—is the universal characteristic of expanded dysthymia and at least most types of dominance. In other words, there may be similar aspects to perception across all cases of dysthymia.

### **Losses and Gains**

Because the Big Three affect many functional traits (see Chapter 7) that may exist as continua, adjusting ser and/or nore with drugs to treat expanded dysthymia can also be seen as producing an exchange of traits, namely a loss/diminishment of some and a gain/enhancement of others. We can call such an exchange ‘lossful’ if it produces a net decrease in quality of life, ‘gainful’ if it produces a net increase in quality of life, or ‘neutral’ if there is no net change. If performed properly, The Adjustment should always produce a gainful exchange, though it may not always be perceived this way because personality and behavioral habits are set up to engage in positive activities optimized for the former Big Three traits. In other words, the person may be more familiar with what they lost than with what they gained. In some people there could be the opposite bias in that there’s a positive novelty effect to The Adjustment that would wear off in time, though others may find such novelty disagreeable. In either case, letting a given person assess the sign of their own exchange may be unreliable. If we could anticipate and then tell them what the gains and losses are, then maybe they could better assess them. So the quality of an exchange may not be apparent immediately but only after one has lived with it for a while. We can even define expanded dysthymia as including everyone who has—or would have—a gainful exchange to The Adjustment, which may include over 50% of

the population. The further the Big Three are from optimal strengths in a given person, the greater the magnitude of the gainful exchange produced by The Adjustment. So The Adjustment has a diminishing return—in other words, a weaker effect—the closer the Big Three are to their optimal, mid-range strengths to begin with. And the concept of gainful and lossful exchanges partly depends on whether there are optimal ranges for ser and nore strength, or instead whether there is an optimal point for each. Finally, Big Three strength adjustment possibly isn't the whole story with expanded dysthymia, as the hardwired brain circuitry probably differs from person to person. That said, adjusting ser and/or nore in everyone will produce some effect that should increase or decrease the magnitude of the dysthymia.

Maybe when The Adjustment is performed on an expanded dysthymic person, he then has less of a specialized personality and is more so a generalist, in that he is more generally capable. In other words, he gains a broader range of skills and talents. If so, treating expanded dysthymia with The Adjustment may not harm society, and may in fact make it function better, possibly much better. However, perhaps it's a good thing for society that a given person may only be able to be adjusted so much.

### **An Analogy**

One can draw an analogy between poor vision (sightedness) and expanded dysthymia; both: 1) are very common; 2) can be improved by medical intervention; 3) may not be present at birth and can have various ages of onset; 4) seem like they would be selected against by evolution, but may in some cases be selected for; 5) may be more common now due to evolutionarily recent changes in the environment, or changes in evolutionary selective pressure; 6) are mediated by complex organs—the eye and the brain—though the brain is obviously more complex; 7) are special cases of the many things that can go wrong with the eye and the brain, though sightedness and expanded dysthymia are by far the most common things that do go wrong with these organs; 8) are of critical importance to the well being and survival of the individual; 9) have a degree of dysfunction that may be a continuum; 10) are similar in that the worse it is the more likely the person is to know that something is wrong, but he may not fully appreciate that something was wrong until it is fixed; and 11) may have a clear, optimal solution, though adjusting ser/nore may be a matter of personal taste in terms of gainful and lossful exchanges.

### **Special Types**

Now I'll provide some comments on four special types of expanded dysthymia: strong nore, strong ser, weak nore, and weak ser. For each of these four types, there may be no single personality type—there are many, just as there are many weak ser mental illnesses. All four of these types may differ from one another in their percentages of males and females, as women, on average, appear to be stronger in nore and weaker in ser than men. By extrapolation from the propranolol study mentioned in Chapter 9, maybe someone with super strong nore detects sadness better in others because he evolved, through natural selection, to recognize discontent in others and thereby lead the way to subversion of authority, though many people may identify with the underdog subverting authority. Super strong ser people may be aloof and compassionate, whereas

super strong nore people may be empathetic, at least in most cases for both types of people. I'm not sure if there's a substantial market for ser weakening drugs, because strong ser is so rare, though many ser weakening drugs already exist. A related point is that there have probably been few cases in which a super strong ser person was given an SRI (which is clearly pathological, as in My Case Study), though there probably have been a lot more cases in which a super strong nore person has been given an NRI, which for them should be pathological. Since the SRIs have unveiled a broad array of people who may be weak in ser (as Michael Norden points out in *Beyond Prozac*), might there also be a broad array of people who are weak in nore? Finally, some weak ser people are cheerful and some are not—does this represent hardwired differences in circuitry? Are both types nonetheless expanded dysthymic?