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# Quality of life:
## What should we measure, and why does it matter?

DANIEL NETTLE

Every government in the world (hopefully) wants to see the quality of life of its citizens raised. Certainly, those citizens want to see the quality of their lives increase. But this raises a problem: how do we measure quality of life? How do we know if our quality of life is getting better, getting worse, or staying the same? This isn't just an academic or a philosophical question. It's a personal one – we all want to make decisions that will make our lives better – and, it is becoming increasingly clear, it's a political one, because the way we decide to measure quality of life will affect the way we allocate our scarce collective resources, what we tax, and what we make legal and illegal.

*Governments have striven to deliver growth year on year, squeezing their other priorities around this necessary objective.*

The dominant paradigm in the decades since the middle of the twentieth century has been to consider economic growth the primary desideratum for knowing that we are going in the right direction. Governments have striven to deliver growth year on year, squeezing their other priorities around this necessary objective. Other things being equal, or even if they are not, more growth in economic activity is better than less growth. This thinking is still at the forefront of decision-making now, amidst the world's economic uncertainties: governments are mainly concerned to return the world economy to growth as quickly as possible. However, criticism of the economic growth-centred view is also growing.

There are a number of grounds for this critique. There is the environmental one: the more of the earth's resources we dig up, cut down, burn, transform through manufacturing, and throw away in landfill, the more the Gross National Product goes up. This is because all of these processes add to the total volume of economic activity occurring. The Gross National Product goes up regardless of whether there is any long-term gain to humankind from using these resources, and takes no account of the lost resource available to the rest of the biosphere and future generations. Gross National Product is also full of paradoxes: if one person from every household in Canada went next door to have his or her dinner, and his or her neighbour charged her thirty dollars for the privilege, then nobody would be any better or worse off financially; the same amount of food would have been cooked and eaten; and the Gross National Product would be increased by millions of dollars. This is because Gross National Product is basically a measure of the amount of *monetized* activity in the economy. So, if services that were previously provided informally

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INSIDE

# Welcome to the winter 2011 edition of Synergy

This is another themed issue of the journal: *The Happiness Issue*.

Our cover essay comes from an international authority on happiness studies. For additional reading on the field of hedonics and its growing academic literature, we direct you to his books and their bibliographies. In this essay, however, he takes the topic a step farther by asking how we define quality of life and go about measuring it.

Also in this issue we begin a likely ongoing feature: film reviews related to psychiatry and psychology. The recent film, *The Future*, is discussed. If you plan to see the picture and want complete suspense, beware, as the review does reveal the plot and how it relates to at least one version of happiness.

Poetry is usually personal, even if the themes are universal. We decided to publish a piece of poetry this time since, if Love is Happiness, then this poem should be included.

We also continue our series, "The Language of Psychiatry," which attempts to explain common psychiatric terms for the non-psychiatric clinician (while maybe even explaining them for the psychiatric community, too). The term chosen for this the happiness issue is, fittingly, *Anhedonia*.

The space previously called "Librarian's Corner" is back again with a short piece on happiness and genetics and the literature regarding a happiness gene.

Our back pages go again to a personal essay exploring a common patient plea: "I just want to be happy". How mental health clinicians respond to this may define the boundaries of the profession and indeed its future.

We hope you enjoy the prose and, as always, welcome your comments.



## *SYNERGY* SUBMISSION GUIDELINES

*Synergy* invites submissions from members of the mental health community in Southeastern Ontario and beyond. We encourage articles on current topics in psychiatry. Our essays are scholarly in outlook but not number of footnotes. We strive to publish good prose and ideas presented with vigour. Articles range from 500 – 1000 words. Longer articles may be accepted.



Articles may be submitted in the form of a Microsoft Word document as an email attachment.


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Hotel Dieu Hospital
Providence Care
Kingston General Hospital
Frontenac Community Mental Health Services
Ongwanada

by people helping one another instead become monetary transactions, then GNP goes up, regardless of whether this actually makes anyone feel any better.

Another critique that is gaining ground rapidly, and very much discussed in a number of countries, is based on the notion of subjective well-being – happiness, if you will[1]. One of the main grounds of this critique is that, although the last fifty years of enormous expansion of the consumer economy has made us (on average) a lot richer, it does not seem to have made us a lot happier. When you ask large samples of people to rate their satisfaction with their lives, on a scale of 1 to 10, you get an average that is around 7 – and that is the same in 2010 as it was in 1950. Although there are some differences by sex, age, and levels of education and income, these are pretty modest. Thus, the charge goes, economic growth has let us have more, but not live better. The advocates of this position then say that what governments should be measuring is not GNP but gross national happiness.

This happiness agenda is being taken quite seriously. Government statistical services are seriously investigating how they could gather data on people's happiness, and how it might be used to assess the merits of different policies. Earnest discussions are being undertaken about optimal metrics and sampling strategies. On the face of it, to a person with hippy and green tendencies such as me, this seems attractive. How humane for governments to consider people's *feelings* rather than just the brute pursuit of ever more.

When you start to think about it more deeply, however, things get a bit more muddled. First, think again about the fact that, in the UK, average happiness has stayed more or less identical at about 7 out of 10 for over 50 years. Advocates of the happiness agenda invoke this as a criticism of GNP as a measure of social progress, but I would say it probably shows that happiness is just a bad measure. Over the last 50 years, Britain has gone through periods of rapid economic growth, and terrible recessions in which unemployment reached worrying levels. We have fought wars in Korea, the Falklands, Afghanistan, and Iraq, and also enjoyed decades of peace. We have had the social democratic settlement of the 1950s and 1960s, and the free-market years since. Are we really saying that despite all of this change, the quality of people's lives *has been the same throughout?* Clearly not.

Instead, I think what happens is that when someone asks you the rather strange question of how happy you are on a scale of 1 to 10, you look around and make some very local comparison, such as with your neighbours or co-workers, or with yourself six months ago. In general, you conclude that there are some ways things could be better, but some really bad things around which you are currently free of, so you give yourself a score somewhere in the middle (where exactly depends largely on your personality). So the overall average comes out about 7 out of 10[2].

Now, if there are large social changes which affect everyone, everyone's life will get better or worse. But when you are asked the happiness question, you still just make the local comparison with others around you, and so you still conclude that you are somewhere in the middle: could be better, could be a lot worse. In other words, happiness measures tell you nothing about the absolute quality of people's lives, but instead about how they rate themselves relative to others at that point in time. This means that whether life gets much better or much worse, the distribution of self-rated happiness is going to stay much the same. Individuals may go up and down the distribution as they are buffeted by life events, of course, but the aggregate happiness is not going to mean a great deal. Certainly, the long-term impact on gross national happiness will be a very poor measure of the desirability of any particular policy, because the long-term impact will be roughly nothing at all.

There is also something else which disturbs me about the happiness agenda. It seems to want to reduce the complex structure of all human motivations to a single index, and a rather crude, acquisitive, individualistic, animalistic one at that. Smokers are made happier in the short term by going out for a cigarette; should we therefore be encouraging them to smoke more often? I am quite happy when I get an hour or two off from my job, but if my job were taken away, my life would be much worse, not better. In other words, the short-term emotional response to an event, and the long-term desirability of that event in one's life, are really rather different things. That's why we can aspire to diet, but fail to do so; why we – perhaps, as humans, uniquely – can set ourselves improving personal agendas even though we know they are going to be hard to keep up. That's why many admirable human beings decide that their personal happiness is less important than a burning moral or aesthetic goal they set themselves. If we reduced every choice to the immediate way we felt, we would make poor choices indeed. The subjective well-being question, though, reflects short-term feelings as much as anything else – we know this because you can manipulate people's responses to it just by giving them one dime just before asking. That dime won't meaningfully improve their lives in any way, yet it shows up in reported increased life satisfaction, because what you are measuring is, to a significant extent, an immediate affective state.

What then should we do? On the one hand, I decry the crude commercialism of making economic growth the primary metric of progress and, on the other, measuring gross national happiness appears to be a fool's errand. What is the alternative to either of these?

This is a really difficult question. I think perhaps the best metric we have of *quality* of life is actually a measure of its *quantity*, namely life expectancy. Even better is a variant called *healthy life expectancy (HLE)*[3]. This is a measure of the number of years of good health a person being born today would be able to expect if current rates of mortality and morbidity remained constant. Why is this a good measure?

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It's a good measure because measuring the quality of someone's life is difficult and subjective, but it's pretty clear that if given the choice between being alive/healthy or dead/unhealthy, almost everyone would choose the former. So the measure captures something that everyone can agree is desirable. HLE gives our capitalist economy its due, because the last century of economic growth has produced very substantial gains in people's expectation of healthy life. That, I think, is the strongest argument in its favour.

HLE also holds consumer capitalism to account for the things it does not do well. The countries with the very highest HLE are not those with the highest GNP. The United States, for example, lags behind countries like Japan, Sweden, and Switzerland for HLE despite being richer. It seems that for HLE, it is not just crude wealth that matters, but also equality of opportunity, social order, and quality of institutions. HLE also points our attention to the terrible inequalities that capitalist countries are prone to produce. In England, HLE varies by up to 15 years between the richest neighbourhoods and the poorest, a shocking indictment of the sharp gulfs in life chances that exist within this small country[4].

Although HLE is largely a measure of physical health rather than psychological experience, I believe it represents a better way of getting at psychological quality of life than asking directly psychological questions. If rates of affective disorders increase – and there is some worrying evidence that they may be doing so, though this evidence is always hard to interpret definitively – then this will be internalized within HLE, because affective suffering is closely linked to physical morbidity, and to increased mortality. If the inequality of economic opportunity goes up, that too will show up in HLE, since there is evidence that inequality *per se* may have negative health consequences[5]. Thus, as a measure, it responds to things we ought to be worrying about.

In principle, then, we should measure the value of any policy by its effects on the nation's health. In practice, it might not be anything like so easy. For a start, there are dozens of policy changes every year, and so any change in health outcomes in the following year could be down to any of them or their interactions. To really be scientific about this, governments are going to need to conduct randomized controlled trials, with different measures introduced in different experimental sites (towns, cities, or neighbourhoods) to establish the effect of the intervention. This is a strict discipline which politicians may be rather unused to following. Even this will not always be possible, since some policies (going to war or adopting new currencies are obvious ones) are by definition national in scale and cannot be piloted experimentally.

Making the impact on health the key metric for good policy could easily be mistaken for the example that there should always be more spent on healthcare. However, this is not what I am saying. Indeed, one of the most interesting things we have learned about human health in recent years is that it is strongly affected by broader social factors than just the availability of healthcare. It is affected by the strength of social relationships. It is affected by economic insecurity. Some of the most fascinating recent evidence for this comes from guaranteed minimum income schemes, also known as negative income tax schemes.

Guaranteed minimum income schemes were championed by economists as more efficient ways than existing welfare arrangements of providing a safety net whilst also giving people incentives to work. They were trialled in a few places back in the 1970s, notably in Dauphin, Manitoba, which for four years had a fully-functioning guaranteed minimum income scheme, the only complete community to have one for a sustained period of time[6]. Individuals always had an incentive to work, but they knew that their annual income could never fall below a defined floor. The effects on economic behaviour were modest, but, unpredicted at the time, the scheme seems to have had quite marked effects on the town's health. The number of hospitalizations declined relative to control communities in Manitoba, and this was particularly true for mental health-related diagnoses. Given the known epidemiologic association between economic insecurity and psychiatric disorder, this should not perhaps surprise us, but it is nice to see it shown in a quasi-experimental, rather than just observational, way.

The Dauphin experiment is a nice example of how a policy that lies in the economic sphere can actually be measured and justified in terms of its impact upon health. The effects on economic activity of the policy were modest. Had someone asked Dauphin residents how satisfied they were with their lives, the answer would probably have been around 7 out of 10 both before and after the scheme. But the potential merits of the scheme show up in a place as unsuspected as hospital admissions rates in subsequent years.

Let us hope for politicians rational and humane to listen hard to this kind of evidence, and use it in making difficult decisions as we move forward.

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# To Ponder the Future

NAM DINH DOAN

"Paw Paw: that's what they called me," explains the cat in the movie, *The Future*, referring to the human couple who have sought to adopt her. Pathologically hopeful for the future and an uncomplicated creature at heart (as cats are wont to be), Paw Paw is the film's biggest optimist. Inexplicably and without basis, she is convinced that her life will be bliss once she moves to Sophie and Jason's home, not a shred of doubt in her scratchy voice as she goes on to describe in detail the love and affection she expects to receive there.

Artist-of-all-trades Miranda July is writer and director to this very contemporary and very indie film – somewhat about "the future," as the title implies, and somewhat not. *The Future* may be described as a schizotypal tragicomedy about Sophie and Jason, the cat owners-to-be (not a cat-centric story per se, in spite of the huge close-ups of furry limbs). On a more figurative level, it is a case study about First World anxieties and, specifically, the all-too-human compulsion to ruminate on the future at the expense of the present.

The Future: *it's more eccentric than Tim Burton's hair, but it's also one of the better movies to come out in recent years...*

"We'll be forty in five years. Forty is basically fifty, and then that's it for us!" reckon Sophie and Jason, a 30-something year-old couple in the throes of history's earliest midlife crisis. Funny, they didn't seem so unhappy before, but in overthinking they have found reasons to be dissatisfied with their lives. In other words, they are neurotics. In some more words, they represent the opposite of the cat. For example, Sophie explains to Jason that amnesia could one day make them forget about their love for each other; therefore, head injuries are an eventuality that ought to be planned for and feared – as if people needed more reasons to feel anxious.

Lacking in the wherewithal to sensibly manage this midlife crisis, they decide to give up their jobs on a whim, the first step towards remedying their (non-)plight, or so the plan goes. Sophie quits as a ballet instructor and languishes at home ostensibly involved in a YouTube art project whereby she films herself doing thirty contemporary dances in thirty days, to which Jason remarks, "No one cares." Her boyfriend's disparagement aside, she finds that she is too self-conscious to perform even one dance. Expecting a miracle, she disconnects the internet for the remainder of the month in a bid to boost her self-esteem. "But why is it being shut off?" Jason asks, as do we. Disconnecting the internet, unsurprisingly, is not helpful in this case. With zero dances and more dissatisfaction than ever, Sophie ends up having an affair with an older man.

Jason, meanwhile, quits as a technical support operator, but he too, like his girlfriend, lacks the wherewithal to find a fulfilling alternative. He figures that the universe always drops hints and that it behooves you to pay attention to the "signs" in order to lead a more satisfying life. Diligently following the "signs," he is handed a job as a door-to-door volunteer for an eco-charity. As he realizes too late, it's a thankless job altogether, he hates the public, the eco-charity is seriously lacking in manpower (Jason is the sole volunteer),

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**TO PONDER THE FUTURE** *continued from page 5*

and, come to think of it, he has never been invested in the ecosystem to begin with.

We as the discriminating viewers have accrued serious doubts about the couple's capacity to problem-solve. This much was apparent in the first scene whereby, stretched out on a sofa, the two are brainstorming ways for Sophie to get a glass of water. Walking to the kitchen and running the faucet simply won't do; the glass ought to be ferried across the apartment by use of a crane, and as for the tap, it behooves Sophie to turn on the faucet at a distance using her "mind" (her lack of a crane and of telekinetic superpowers puts a kibosh on that plan. Five minutes into the scene, Sophie is still without water). Later, regarding Sophie's affair, her new lover Marshall proposes two options, either to go on lying to Jason or to tell him the truth. As she puts it, "I can't do either."

In the film's last act, Sophie does the latter and confesses her affair to Jason, who, desperate and unable to cope with the news, literally "stops time" – symbolized by placing his outstretched hand on top of her head, which apparently makes the rest of the universe go motionless (it happens, I suppose). Hungry and exhausted, he goes on clinging to his girlfriend's scalp, supposedly for days, to which the Moon politely remarks that maybe he ought to rest. (Miranda July imagines the Moon to be wise and to speak in a friendly voice, like your sixty year-old neighbour with the disarming shirt-and-sweater ensemble. Or maybe the Moon is a figment of Jason's imagination, a plea from his subconscious. In filmic terms, and art house films in particular, such distinctions are altogether unimportant.) If he lets go she will leave him, reckons Jason, convinced that their relationship *will* – not *might* – end in breakup, never mind that he knows next to nothing about the situation. Whilst jumping to conclusions, he goes on to catastrophize further that he and Sophie will not have a future together, which prompts a retort from the Moon to the sound of, "But you don't know that for sure."

Jason's trust in fate, the future, and uncertainty in general has been sorely injured throughout the course of the story. At this point, his sense of well-being becomes increasingly reliant on impossible guarantees. Barring the promise of a bright future between him and Sophie, for instance, he intends to keep time frozen indefinitely. "If it's going to work out, could you just give an indication?" he pleads, appealing to the Moon's power of clairvoyance or whatnot, to which his interlocutor deadpans, "I don't know anything. I'm just a rock in the sky."

Odd movies like *The Future* typically run the risk of overindulging in their oddities, thereby imploding from a lack of actual subject matter, but this is not the case here. Amidst jarringly bizarre situations, both real and imagined, the melancholia of human hubris is felt nonetheless, and the implication that contentment (or a lack thereof) is largely a state of mind – at least for some of us.

*The Future:* it's more eccentric than Tim Burton's hair, but it's also one of the better movies to come out in recent years, and comes recommended by all ten of my fingers.

Smith, SB (Producer), July, M (Director). *The Future* [Motion picture]. United States: GNK Productions; 2011.

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# Discovery

BARINDER SINGH

I had assumed that the world was round
You had always known that it was flat
Halfway through the journey
I had often thought of changing
My mind
You
Us
Them
The shapes of things that existed
Fantasies that did not

Just as I had given up
You appeared
You were somber
I was chatty
We were both reflective

It was then that the edge appeared
I saw an abyss
You saw an adventure
I had been afraid
You were daring

You convinced me
I am easily led
We had
Hung our legs over the edge
In awe of our discovery

The world

The wonder

The wizardry – that brought us together

But mostly we had marvelled
That you had found me
And I had recognized you

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# THE LANGUAGE OF PSYCHIATRY

If I am forever describing the porterhouse with truffles at a certain restaurant in Tribeca, I am just a snob. A steak supper in New York City is all that really happened. However, precision in language is not always a result of pretention. I tell my friends I broke my arm playing hockey, but I tell other physicians that I broke my distal radius, not because I want to insult my friends' intelligence or because I want to traffic in technical jargon with other doctors, but simply because I want to be precise when appropriate.

Medical language is rich in Latinate phrases (*status epilepticus*), food allusions (blueberry muffin baby, chocolate cyst), and eponyms (Smith fracture, Capgras Syndrome). Some terms are of little but historical use, but many serve to describe symptoms and diseases with precision:*Status Epilepticus* denotes diagnosis, urgency, and prognosis all in one splendid fusion of Greek and Latin.

The language of psychiatry should not be foreign to other physicians. It is not different in quality from the accurate and useful language all doctors use to describe signs, symptoms, and disorders. Its vocabulary may be larger and the symptoms described sometimes bizarre; nevertheless, the meanings of common psychiatric terms must be familiar to all physicians so that, at the very least, we can communicate in consultation letters. It is as basic and necessary as pointing to the clavicle or finding the carotid pulse.

## Anhedonia

When a child says, "I'm bored," he is not usually tagged as anhedonic, even though his grating statement implies little pleasure in all the activities that have been suggested over the afternoon and little interest in all the crafts organized at great effort and expense. Perhaps he has a surly temperament, ADHD, or a sore throat. Maybe all the available activities are far below his age level or IQ, or maybe he is bored when compared to playing Wii at his friend's house that morning or when compared to sitting cross-legged in his room finishing off his Halloween candy.

Anhedonia – the "loss of ability to experience pleasure"[1] – is difficult to measure and its value in psychiatric diagnosis still under investigation. First, what does one measure? Should we ask the young man who claims depressed mood whether he still enjoys sex? The bored child might still enjoy the mini chocolate bars in the bottom of his plastic pumpkin. Should we ask the tearful older woman with disrupted sleep whether she still gets pleasure from watching *60 Minutes*? Investigative journalism can include disturbing segments on serial killers that might not qualify as pleasurable to octogenarians who live alone, just as cutting out paper dolls does not qualify to the bored seven year-old boy.

Second, are self-reports valid? "Mood" is often defined as an emotional state that is sustained and "colours the total experience of the subject".[2] Therefore, we are probably actually assessing a "feeling" or "emotion" – something transient and short-lived – when we ask a patient's mood, even if we qualify it with "over the last two weeks," since humans tend to offer their most recent emotional states as the dominant ones. Perhaps a malodorous group who shared the waiting room caused a particular feeling to arise in our patient, which was then volunteered as the dominant mood lately. When we rely on self-reports for the absence of pleasure, we face the same problems with validity.

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Several depression scales include interest in sex as a measure of anhedonia. It's important to note that this measure doesn't grade how much pleasure is experienced through sex, or even if sex occurs, but simply whether *interest* in it is maintained. This would seem to bypass the conundrum of the complexity of sexual pleasure: the intricacy of nerves and blood flow, the attitude of a partner, whether arguments have ruined the mood, and memories of past sexual experiences all jostle to make the *pleasure* resulting from sex too difficult to measure. If interest alone is questioned, however, it would seem all these complexities can be avoided. The patient completing the scale still has interest so she's okay.

Two points must be made here, however. First, physical illness can blunt the capacity for pleasure and even interest in certain potentially pleasurable pursuits.[3] This is especially relevant to sexual desire as physical illness can change, not only the intensity of pleasure, but even interest itself and thus render the depression scale invalid. Second, this all emphasizes how loss of pleasure and loss of interest can be quite different, and warns clinicians to be mindful of which they are screening for, although it is unclear which is more useful in psychiatric diagnosis.

What is clear is that anhedonia holds an important place in the DSM-IV criteria for diagnosing Major Depressive Disorder. It is one of two criteria that must be present – illness-defining features, really – to make the diagnosis of MDD. It is more important than suicidal ideation (for diagnosis if not for risk) or disturbed sleep or feelings of guilt or loss of appetite. In fact, if anhedonia is present, the patient can deny having even depressed mood itself (although I find this is seldom the case) and still qualify for the diagnosis. While I rarely interview an anhedonic patient who denies feeling depressed, I quite frequently interview people who report depressed mood but endorse a continuing and robust capacity to experience both interest in pleasurable activities and the pleasure itself. Does this mean they do not suffer from Major Depressive Disorder? Does it mean they will not benefit from an antidepressant? Research doesn't show clear answers to these questions.

What some research does support, however, is the continuing validity of subtypes of depression. That there may be different depressive disorders with not only different symptoms, but different causes and even pathophysiology, should probably not be surprising given our still meagre knowledge of depression. Anhedonia is relevant here as patients with the melancholic subtype of depression tend to endorse it more as a symptom, along with weight loss, early morning wakening, depression worse in the morning, and slowing of thought and movements.[4] This subtype of depression is sometimes referred to as "endogenous" or "biological," older terms that are not in vogue but retain some utility nonetheless as they describe depression that may not have any stressful triggers or identifiable causes and may respond better to certain antidepressants, or better to biological treatments period.

Happiness has many facets including a sense of well-being, feelings of contentment, and even feelings of pleasure. It is not certain from the existing literature, but it might just be true, that what keeps us from despondency, guilt, self-loathing, and ultimately suicide, can be accessed by the psychiatrist, not by asking about meaning or any yearnings for oneness with a higher power, and not by probing a sense of satisfaction or whether one is living up to one's potential, but instead by asking about the most primitive of happy pursuits – the appetites – and whether one can get pleasure from eating, copulating, or sitting in front of a TV, and whether one even has the desire to try.

ERIC PROST

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# Happiness: Questions and Answers

KAREN GAGNON

The word "Happiness" ignites many questions. Here are some current answers to common questions about happiness and happy people.

**What makes a person happy?**

Dr. Martin Seligman, Director of the Positive Psychology Center at the University of Pennsylvania and founder of positive psychology, suggests that happiness lies in our internal qualities and character strengths, not in external events.[1] For further reading on this question, visit Dr. Seligman's "Authentic Happiness" website.

**Is happiness genetic?**

Jan-Emmanuel De Neve, Behavioural Economist at the London School of Economics and Political Science, demonstrated a link between an individual's happiness and a specific genetic condition. He does acknowledge that this gene alone does not determine our happiness or well-being and that other genes and experiences will continue to explain an individual's level of happiness.[2]

In addition, researchers from UCLA have linked the oxytocin receptor gene (OXTR) to psychological well-being.[3] The study demonstrated that individuals with a specific version of the gene have substantially lower levels of optimism, self-esteem, and mastery, and significantly higher levels of depressive symptoms. The researchers explain that, although there is a genetic link to optimism, other factors, including a supportive childhood, supportive relationships, and other genes, also play a role.

**Can happiness be measured?**

Yes it can!

The Oxford Happiness Inventory[4] was developed by Michael Argyle and Peter Hills and has been tested for reliability and validity. It can be found online at Meaning and Happiness: http://www.meaningandhappiness.com/oxford-happiness-questionnaire /214/

The Subjective Happiness Scale[5] by Sonja Lyubomirsky has also been validated and can be found online at The How of Happiness: http://chass.ucr.edu/ faculty_ book /lyubomirsky/Quiz/subjective_happiness.html

**Do happy people live longer?**

According to some research, happiness does have a protective effect on people's health and hence their longevity. Researchers at the Columbia University Medical Center found that positive affect was protective against coronary heart disease.[6] In addition, a meta-analysis based on 24 studies found that happier people live on average 14% longer than persons who are unhappy.[7] And, of course, there is the long-running "Nun Study," which found a positive correlation between subjective happiness and life span.[8]

**Can people develop happiness?**

Here's one definition of happiness: a state of well-being and contentment that many people strive for. Research does support the notion that people can learn to increase their positive mood, bringing more meaning and satisfaction into their lives. There is a proliferation of resources, including books, self-help groups, websites, and counselors to support individuals in this quest. A quick search on Amazon.com on "happiness" returned a list of 21,621 books! One might conclude that an industry has developed in response to the pursuit of happiness.

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# I Just Want To Be Happy

ERIC PROST

Occasionally, my patients come up with attainable and realistic goals: "I would like to be able to get on a city bus without having a panic attack" or "I want to stop cutting myself". Usually, however, the goal is broad, utopian, vacuous, annoying, and heartbreaking: "I just want to be happy".

I used to grind my teeth in curmudgeonly reverie at this response. As a pessimist with a dim view of human nature, I would chuckle at the naiveté, and attempt to guide the dreaming patient towards an objective likely to be accomplished in this life. I remember surprising a medical colleague when I disagreed that the aim of my profession of psychiatry was to make people happy. I disagreed because the aim seemed unattainable, a recipe for despair on the part of the psychiatrist or for interminable follow-up visits consisting of doctor and patient struggling, futilely, against the vicissitudes of life. It seemed equivalent to a vascular surgeon and his patient settling for nothing less than pristine and elastic blood vessels throughout every year of the allotted three score and ten, despite fast food, injuries, and aging – no plaques, no narrowings, no varicosities even. The achievement of an ideal.

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The American Declaration of Independence states "that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness". This last right sounds to the 21st-century mind like a vague yearning, that the 300 million American citizens to our south should have the right to pursue happiness, that no government should hinder this chase, that, in fact, it should ensure its citizens can long for and search for happiness as best they can.

Garry Wills, in his book-length gloss on Thomas Jefferson's Declaration of Independence, defines "the pursuit of happiness" differently.[1] By examining the Scottish Enlightenment and its influences on Jefferson, Wills shows that this "pursuit" should be understood, not as a yearning in a human, but as a "uniform necessity of his nature, something as regular as a magnetic needle's turn to the North". He attempts to show, by quoting numerous influences on Jefferson, that the pursuit of happiness was not a "mere aspiration," but really a natural law. This pursuit in its 18th-century context is a given, something innate, almost akin to the instincts for food, shelter, or Bowlby's drive for attachment. It is something we, as humans, do.

If enlightened Scotsmen and revolutionary Americans were right, then I am wrong. When patients cry, "I just want to be happy," I should not be surprised, nor should I scorn. They are just expressing what humankind has striven for "as regular as a magnetic needle's turn to the North" for generations. And if it's a law of nature, an unalienable right that even King George III was not to stand against, who am I not to further its cause and nurture it, day in and day out, in my psychiatry clinic?

But even if it is a human drive, is it the goal of psychiatry?

I have seen patients experience life-changing events and yet get away without changing their lives. Sometimes I have even helped accomplish this. Through medication and psychotherapy I have aided and abetted the smoothing of bumps in a life, tried to ease the impact of losses and catastrophic events, and attempted to restore normalcy after or in the midst of trials, all because I am in a caring profession and the patient just wants to

be happy. I could rightly be accused of mitigating the effects of potentially life-changing events so that patients do not, in fact, have to change quite as much in response to them. Long-term psychotherapy might ask difficult questions; in prolonged psychodynamic therapy a patient might get asked something equivalent to "what did you learn from this?" or, at least, squirm at the implications of a telling interpretation. But time-limited therapies often attempt to bolster good coping strategies and build up patients, restoring equilibrium through structure, routine, good eating habits, regular exercise, and a little cognitive restructuring. And in this pursuit of happiness, our patients may miss out on something more.

Allan Horwitz and Jerome Wakefield argue in their 2007 book, *The Loss of Sadness,* that our current DSM classification of mood disorders fails to distinguish between normal – and even healthy – sorrow and true depressive disorder[2]. Psychiatrists diagnose "Major Depressive Disorder" when a list of symptoms is present, regardless of whether the patient has, on the one hand, begun without warning to feel miserable and has ceased to enjoy anything at all (including bathing), or has, on the other, recently lost his job or his marriage and now feels low and seldom hungry and has fitful nights. They wonder whether we are doing society a service by proclaiming an epidemic of depression that requires medicating, or our patients a service, from an evolutionary perspective, when we imply that sorrow is pathological. Could the mind and the body not possibly be benefitting from feelings of sadness when life events seem against us? Could the very symptoms that cause us discomfort when sorrowful not be helping us even as they force us to step back, take time off, devise ways to avoid repeating the same mistakes in life, and even mourn?

Could the result of these endeavours sometimes forced upon us be called wisdom? The pursuit of wisdom is not a phrase that found its way into America's founding documents. And yet ancient Israel's King Solomon was praised for asking for it when he was given one wish. In Solomon's case, this attribute is referred to as wisdom, insight, or discernment. This is definitely not an innate drive. I shield myself from insight at every turn with defences both mature and primitive. When life is difficult, I do all I can to make it comfortable again and, when it is, make it remain so. Who cares whether I learn from mistakes as long as I can keep eating out? Who cares whether I exhibit discernment throughout, and especially at the end of, a rough patch of life as long as I get back on my feet? And who cares about insight as long as I consume fibre, walk 40 minutes three times a week, and watch my cholesterol?

Perhaps it is unnecessary to help our patients search for either wisdom or happiness. As a psychiatrist, I could avoid these problems altogether and leave happiness out of it. I could continue on diverting patients' goals from happiness to boarding buses anxiety-free or getting more sleep or drinking less caffeine or having more sex (or less). I could narrowly define my task as eradicating or managing the symptoms of mental illness. Nephrologists don't make patients happy; they treat painful urination and swollen limbs and flank tenderness. Happiness as alleviation of suffering might be a by-product (like creatinine), but not the goal itself. With a similar narrow view of psychiatry, the absence of sleep disturbances, panic attacks, hallucinations, or memory problems might result in happiness, but this would not be the objective itself.

This is a tempting view of psychiatry to take. It would give boundaries to a profession that has few. When the gastroenterologist does all he can, he tells the patient this and books a follow-up review in 6 months; when the neurologist determines the patient's symptoms do not fit with any anatomical lesion or pathophysiological disease, she tells the patient and the family physician this and closes the file. When the psychiatrist cannot determine a cause, he asks more questions, tries a medication anyway, or tries a small

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dose of a fourth one to treat just one of the symptoms. When the psychiatrist finds no evidence to diagnose any one major mental disorder, he calls it a "Mental Disorder Not Otherwise Specified" or an "Adjustment Disorder" or sees the patient back in follow-up anyway because, disease or no disease, she is in distress. Narrower definitions of the psychiatrist's craft would solve these problems for the psychiatrist, if not for our patients or those referring to us.

However, if society has come to expect more from our profession than just treating the symptoms of mental illness, and if the pursuit of happiness, however innate, is too broad and even unattainable, and if its pursuit can actually anaesthetize patients to the lessons of life, what is our task? The task of instilling wisdom is a worthy one, but almost laughable in scope, especially when, as psychiatrists, we are not that wise ourselves. Society already expects more of us than we can deliver (although we don't often acknowledge our limitations or the fact that, crowned as emperors of happiness as we are, our new clothes are often nonexistent). And if we are to remain secular in our prescriptions and leave religion and spirituality out of it unless the patient himself indicates otherwise (which is, admittedly, a big condition for many patients), what is our task?

Perhaps happiness is a worthy goal for us to pursue with our patients, after all. If the search for it is instinctive and irrepressible, our patients will continue to reach for it whether we like it or not. So how can some degree of happiness be attained? I suggest a starting point.

The Enlightenment view as propounded by Wills was that humans are most happy when engaged in virtuous actions for others. This was altruism with a dose of self-interest, altruism that benefits, not just the recipient of the largesse, but also the one exhibiting the virtue. This does not disqualify altruism as altruism though. Altruism as a psychological defence has this connotation as well: the mother who endows a cancer research unit after her daughter dies of the disease derives at least psychological benefit from her actions. These 18th-century thinkers believed that virtuous actions benefitted those performing them as well as society – and that is why people would even bother to engage in acts of beneficence at all. As the philosopher Francis Hutcheson (d. 1746) wrote, "the surest way to promote...private happiness [is] to do publicly useful actions."[3]

It is arguable whether the ensuing 250 years have proven that the personal benefits of altruism are sufficient to drive a torrent of virtuous actions resulting in sustained collective benefit. If it has been disproven, perhaps our job or even duty as psychiatrists is to repeatedly ignite behaviour in our patients that will benefit others, because looking outside the self will benefit the self immeasurably as well. In an age of increasing focus on "self care" both in pop psychology and psychotherapy, the altruistic words that sound so very 18th-century and Scottish may be useful because they are not at all 21st-century and Canadian. They may deliver us and our patients from the tyranny of ourselves and the pride and misery that invariably follow.

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