

Sociological Conceptions of Happiness and its Implications for Psychotherapy and Public Policy

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Abstract

This paper critiques the usefulness of cognitive-behavioural therapy, which is often seen as a means of redressing the loss of community and friendship networks within society. Therapy in this context they runs the danger of becoming an iatrogenesis at worst and just another 'technology of mood' at best. In this paper we develop the critiques made elsewhere and provide a more nuanced argument that considers a wider range of psychological therapies. While all psychological therapies operate at an individual level, there are wide differences in the epistemological stances taken by differing therapeutic schools. Cognitive-behavioural therapy focuses on the idea of dysfunctional thinking within the individual, psychoanalytic therapy focuses upon developmental legacies, whereas person-centred therapy focuses on currently active social influences. In this form one to one therapy can be a route to change which is compatible with our sociological critique. However, the broader criticism that psychological therapies attempt to compensate for breakdowns in friendship and social networks remains. Furthermore reviews of psychotherapeutic outcome data and qualitative enquiry both point to the experience of authentic relationship rather than psychotherapeutic technique as the major determinant of outcome. Preventing social dislocation rather than trying to repair it post hoc should be the goal. This would beg a wider range of questions such as; what does social isolation actually mean in contemporary western society and what does this mean for people with mental health problems in particular? What are the various ways in which social networks provide support functions and what may be missing in an individual's life and then what can be done to try and compensate for that lack?

Introduction

The study of happiness gathered new momentum a decade ago when the economist Richard Layard proposed that Governments should focus policy on the pursuit of happiness rather than wealth [1,2]. Layard's analysis revealed that, in general, happiness in western countries including the UK had not increased despite significant increases in GDP since the end of World War II. Although increasing income boosts happiness for those living in poverty, Layard found this relationship breaks down once a certain level of National wealth is achieved [2]. Comparison of happiness across countries reveals that once incomes reach around US\$20,000 per capita, increased wealth has no impact on aggregate happiness. Work by Wilkinson also shows that increases in income at above this level has little impact upon improvements in health, and that societies then need to focus upon service access and leveling inequalities for health gain [3]. As a consequence, Layard encouraged the adoption of the underlying philosophic principle, promoted originally by Jeremy Bentham and the 'Utilitarian School' that society should aim at producing the greatest possible sum total of happiness [4].

In this paper, we will provide an overview of these developments, followed by a critical sociological analysis which points to limitations and future directions for policy and practice.

Happiness Research and its Implications for Policy and Practice

Layard reports seven factors that large scale surveys have identified as affecting our happiness within a Western context [2]. These factors are:

- family relationships;
- financial situation;
- work and job security;
- community and friends;
- health;
- personal freedom (essentially civil liberties); and
- Values (a religious or spiritual aspect to life).

When the impacts of these are measured qualitatively, the factors that have the largest negative impact on happiness are marriage breakdown, becoming unemployed, perceived poor health and low personal freedom (in that order).

Layard argues that this helps to explain why increased wealth has not improved happiness in society. In the same period that average wealth has doubled, marriage breakdown has increased significantly. Community trust has decreased [5], job security has been sacrificed in favour of increased productivity and lower unit costs and self-perceptions of health and wellbeing have plummeted as people are flooded with media images of perfection. Furthermore, once above the US\$20,000 per capita income it is wealth relative to peers that counts, not absolute wealth [2]. One of the greatest impacts of this is on taxation policy. Traditionally taxation has been seen as a distorting

influence, so carrying an assumption that lower tax is always desirable and therefore requiring a high level of justification. However, Layard shows that higher incomes work against happiness at a societal level in two main ways. The first is related to rivalry. If one person's income increases, their happiness increases, but that of their peers decreases by up to one-third as much because relatively, their peers are now worse off. The second is what Layard calls habituation. That is, the increase in happiness from a rise in income reduces over time as people get used to the new living standard. For example, a new mobile phone resulted in significant happiness in 1992 but now only a 4G iPhone 6 will do it. This habituation is unforeseen and therefore, he argues, results in much wasted expenditure. Layard estimates that up to 30 per cent of increases in income are placed in 'over-investment' in material possessions.

Layard's conclusion is that taxation is therefore corrective, not distorting. This is a fundamental challenge to conventional thinking. According to these approximate numbers, a top marginal taxation rate of 60 per cent would be a 'neutral' figure. It is, in fact, the typical marginal tax rate in Europe, where happiness is generally greater than in the US or Britain. The decreasing positive impact of increases of wealth on happiness also suggests a strongly progressive taxation system. This is reinforced by the work of Hutton and others who illustrate the concerns that people have about the disintegration of social values when public services begin to run down in low tax regimes [6]. Comparisons are made by Hutton between levels of concern about public squalor in the USA with its run down public services and in Europe where services have been largely maintained. The clear implication is that happiness is positively associated with public service provision.

There is much in Layard's broader arguments that are attractive, in particular that the underlying thrust of Layard's argument seems to critique individualistic competitive society and is effectively arguing for a new form of welfarism. However, Layard's focus for a happier society is not upon structural change or with a reordering of the highly competitive liberal capitalist economic system (despite his critique of consumer culture) or even with a re-establishment of community, but rather upon therapy and how we think about ourselves.

In these terms, Layard has suggested the need for an additional 10,000 new clinical psychologists and psychological therapists to be trained in order that depression, anxiety, and schizophrenia in the United Kingdom can be treated according to the standards of national evidence based guidelines. As Shaw and Taplin report [7] these proposals initially met with mixed and critical reaction but were then endorsed and enacted by Government. The main critique of this paper is that such strong a commitment to expanding CBT and other evidence based psychological approaches individualises wider social issues. Furthermore operationalization of these proposals also threatens a reification of the notion of community support by replacing it with contact with therapists.

Therapy as a Pathway to Happiness

Jeremy Bentham's "greatest good of the greatest number", has been critiqued before. For Marx, a productive inquiry had to investigate what sorts of things are good for people — that is, what are our true natures, alienated under capitalism. Second, Marx argues that human nature is dynamic, so the concept of a single utility for all humans is one-dimensional and not useful [8]. Interestingly Pope John Paul 2 had a similar view "Utilitarianism is a civilization of production and of

use, a civilization of things and not of persons, a civilization in which persons are used in the same way as things are used" [9]. We also have concerns over Layard's adoption of Benthamite principles. A major feature of his proposals has been to encourage the availability of psychological therapies as a way of resolving unhappiness and improving economic efficiency. As a result, largely of his influence, considerable NHS investment has been committed to providing an unprecedented increase in available, publically funded therapists in the form of the Improving Access to Psychological Therapies (IAPT) programme. The initiative has been based upon a pair of related assumptions: first, that unhappiness and disability is associated with mental health problems and can be viewed as the result of one or other of a set of discrete conditions and second, that appropriate psychological therapy can be an effective way of treating such conditions, and therefore reversing unhappiness and alleviating related disability.

The IAPT programme began in 2006 with demonstration sites in Doncaster and Newham, focusing on improving access to psychological therapies services for adults of working age. In 2007, the Department of Health published an implementation plan which committed the government to £33 million in 2008/09, a further £70 million in 2009/10 and a further £70 million in 2010/11 [9]. This money was to be used by NHS commissioning authorities to fund distinct provider organisations offering unprecedented access to psychological treatments. By 31 March 2011, 142 of the 151 Primary Care Trusts in England had a service from this programme in at least part of their area and just over 50 per cent of the adult population had access. 3,660 new cognitive behavioural therapy workers had been trained, and over 600,000 people started treatment. Over 350,000 completed it, over 120,000 moved to recovery and over 23,000 came off sick pay or benefits (between October 2008 and 31 March 2011 [10]. This final claim reflects an important feature of the rhetoric encouraging the Exchequer to make such a commitment. In 2004 Layard had been able to claim that "there are now more mentally ill people drawing incapacity benefits than there are unemployed people on Jobseeker's Allowance" [1]. In 2007 Oxford Economics reported that "in 2006 there were nearly one million recipients of Incapacity Benefit due to mental and behavioural disorders. This is 40% of total Incapacity Benefit recipients. This is similar to the total number of unemployment benefits claims in the UK [11]. On the basis of such figures and results from the IAPT Demonstration sites, it was estimated that the programme could save the NHS up to £272million and the wider public sector would benefit by more than £700 million: a good return on an initial investment of £173 million. The proposal suggested that a programme of improved access to psychological therapies would result in considerable savings on welfare benefits costs and, given the reasonable assumption that unresolved mental health difficulties are a significant source of unhappiness, it would also make a considerable contribution to the "greatest good of the greatest number".

Unfortunately this promise is not being realised. Five years after initiation of the IAPT programme, mental health difficulties remain one of the most common reasons for sickness-related welfare benefits [12] and the rate at which NHS practitioners are prescribing antidepressants has continued its inexorable rise. In England, some 25 million prescriptions for a course of antidepressants were issued in 2000. That figure had risen to nearly 40 million by 2009 [13], and it has continued to rise at a rate of some 10% per annum [14]. What is more the percentage of incapacity Benefit claimants with mental health problems has not decreased either [15]. At these levels of

analysis, making therapy widely available does not appear to be making a significant impact upon wellbeing. Therefore, it could be argued that Layard's assumptions: that unhappiness and disability associated with mental health problems can be viewed as the result of one or other set of discrete conditions, and that appropriate psychological therapy can be an effective way of treating the condition and therefore reversing unhappiness and alleviating related disability, are flawed. We believe that they are based upon a mistaken oversimplification of the relationships between mental health difficulties, therapy, disability and happiness which deserves clarification.

A distinctly different field illustrates this complexity. More than a century has passed since first publication of *The Secret Garden* by Frances Burnett in 1911 [16]. The novel illustrates the consequences of assumptions of disability and its limitations, and only indirect associations between rigid medical and therapeutic conventions and expectations, and personal outcome. Colin had been assumed a cripple and consigned to a life of dependency and unhappiness. Relationship, care, curiosity and a certain amount of ingenuity enable his redemption, or in contemporary language, recovery. The intervening century has seen great strides in change towards those with significant physical disability, culminating in the celebration of triumph over disability which was the theme of the London Para-Olympics of 2012. Although many of those who took part, and those many more who live fulfilled, happy and flourishing lives despite significant physical disability may welcome and benefit from professional healthcare support; none have achieved their recovery exclusively because of it. Most importantly, their ability to achieve and flourish has not been dependent upon, or waited for, effective "treatment" of their "illness". They have achieved autonomy and a measure of happiness in spite of their disability. The New Economics Foundation have identified 5 alternative pathways to wellbeing – which are, 'Connect; Be Active; Take Notice; Keep Learning and Give' which seem far more relevant to improving people's lives than the actions of therapists [17]. These pathways are also used in the mental health recovery process by use of music, dance and art as forms of therapy.

The journey taken by the Disability Rights Movement across the twentieth century is one that could be usefully mirrored by a similar approach to psychological difficulties. Important stages on that journey have been normalisation, dissociation of the assumption that one form of disability implies global disability, and assimilation of the fact that recovery of autonomy and a measure of happiness are not entirely dependent upon professional input. All of these are poorly developed in the mental health field, and as result there is a large and steadily growing number of unnecessarily disabled and unhappy individuals who are trapped by their assumed status, in the same way as Burnett's Colin is trapped at the beginning of the story.

Mental health difficulties are troubling, not only to those suffering but also to those around them. Distress, despair, fear, confusion or anxiety provoking behaviour all evoke strong feelings amongst those witnessing them, and sometimes people in such a state do behave in a dangerous or reprehensible way. Therefore, it is not surprising, that there is a long and continuous history of social distancing and institutional sanction in response [18,19]. Indeed one of Jesus' earlier miracles was to cast out demons from a socially marginalised madman. Confinement in one context or another was standard practice until the middle of the twentieth century, and the power of a label intimating a mental health difficulty remains considerable. Stigma and other forms of social exclusion are commonplace.

Amongst these are adverse experiences in the workplace, social settings, relationships, health-care facilities and at the hands of the police and judiciary, in ways that would now be considered unthinkable if directed towards someone with paraplegia, or, perhaps even more strikingly, towards someone from a racial minority [20]. Normalisation and an assumption of wider capability remain a distant aspiration for many who have become identified as one with a "mental health problem", even though other previously marginalised groupings now expect to enjoy them.

The anxiety provoked by a particularly distressing, threatening or seemingly self-destructive person also leads to a search for expert help. Most who come into contact with mental health professionals and acquire the identity of someone with a mental health difficulty will have done so via a route which began with troubling behaviour that had caused others sufficient concern to seek professional help on their behalf, or oblige them to seek it [21]. The point at which understandable emotional distress, such as bereavement or romantic disappointment becomes "mental illness" is commonly determined not so much by the form it has taken, but by the extent to which the sufferer's immediate support network is able to accommodate the resulting difficulties. Once health care professionals are engaged in assisting with a distressed or confused individual it is but a short step for them to take before being conferred the identity of one with a mental health problem, and the labelling that goes with it. As happened in response to Colin's assumed spinal disability, the experience of a troubled person who has sought or who has felt obliged to seek professional help is frequently one of becoming unjustifiably identified as incompetent, untrustworthy, a source of shame and dependent upon patronising support. This commonly occurs quite independently of the nature of their difficulties. Instead it is a direct reflection of common, prevailing discourse concerning strong emotional or psychological reactions.

Many of these consequences can be viewed as a result of applying or assuming the classic sick role framework [22]. The "patient" is incapacitated in a way that may benefit from expert attention, they are relieved of responsibility but lose autonomy, they are obliged to submit to treatment, and the situation is considered to be short term. Williams [23] has provided a useful commentary upon the strengths and weaknesses of this classic description when applied to conditions that do not conform to this stereotype and Middleton [24] a comment upon the weaknesses of applying it to mental health difficulties. Central to both of these is the expectation that professional input may be productive and has something to offer that other sources of support do not. The authority to engage the constraints of the sick role framework is only legitimate if doing so will lead to the beneficial application of specialised knowledge and skills. When this does not apply, the constraints of the sick role framework can bring more harm than good, particularly, as we have argued, in the case of mental health difficulties. What might be learned from the journey taken by the Disability Rights Movement through the twentieth century is that many with conditions that were not going to alter significantly as a result of specialised, professional intervention, had more to gain by eschewing the sick role than they had by embracing it. What is also becoming apparent is that the same is true in relation to mental health difficulties. Despite half a century of intensive biomedical research, contemporary medical treatments for depression and psychosis are no more effective than their 1950s predecessors. There is still no understanding of why they work when they do, and many now attribute much of their efficacy to an enhanced placebo effect [25]. Put under the spotlight of extensive review and meta-analysis, the efficacy

of psychological treatments appears to reflect more the ability of the therapist to form a supportive alliance with their client, than it does any specific technical skill they might bring to the consulting room [26,27]. When someone with mental health difficulties does respond to treatment it is probably more as a result of a healing relationship, (which may have included the administration of a medicine they had faith in), than because the health care professional did something “expert”.

Layard’s therapeutic approach fails to take this complexity into account, and as a result could be causing unintended harm. By conceptualising unhappiness as something that a therapist can alleviate; he frames it as something amenable to professional intervention, and in so doing (perhaps unwittingly) consigns the client to certain aspects of the sick role, which, as we have outlined, can have particularly adverse consequences in a mental health setting. There is no known data that might link this proposition to the lack of impact IAPT has had upon sickness benefit claims and antidepressant prescription rates, but the presence of this facility, framed as it is, does confirm the view that emotional difficulties, and therefore by association, unhappiness, are an illness to be treated by professionals. That is not a position that would generate many successful parathletes.

Finally, Layard’s position, that happiness is something that can be achieved by instrumental professional intervention is emphasised by his choice of psychotherapeutic technique. IAPT provider organisations have been explicitly instructed to focus upon making the available therapy Cognitive Behavioural Therapy (CBT). This is a form of psychotherapy pioneered by Aaron Beck in the 1960s and could be (crudely) described as a form of internal monologue. By teaching people to identify their negative thoughts and replace them with positive ones, cognitive therapists try to enable people to master their emotions. The basic concept is not new. Aristotle first pointed out that emotions both influence and are influenced by the thoughts we have. By eliminating thoughts that promote bad moods and to encourage thoughts that foster pleasant emotions, people gain a measure of control over their emotional state and lift themselves out of depression or anxiety by will power. Cognitive therapy teaches specific techniques for identifying and removing negative thoughts. When used by a trained therapist it can be as effective in treating depression as drugs such as Prozac. However we wonder whether most of the efficacy attributed to CBT is not due to the advice of the therapist, but more the expression of empathy that the sufferer experiences. Historically there may have been political reasons for Layard’s expressing an interest in CBT. By virtue of the very fact that it is a particularly instrumental approach to psychological therapy, it is also particularly amenable to evaluation by conventional medical-style, clinical trials. An idealised CBT therapist addresses identifiable difficulties the client is suffering using an identifiable technique, and so it is notionally possible to measure the extent to which application of the technique has led to desirable change. Although, as we will argue, this is commonly a gross oversimplification of processes associated with psychological change, it is a seductive framework which appeals to those seeking cost-effectiveness from public services and those wedded to the ideology of evidence based medicine. These financial and bureaucratic considerations have undoubtedly influenced the form IAPT has been obliged to take, and as a result obscured the notion that empathic relationships are more important to the promotion of happiness than technological interventions. This is something we will develop in the following section.

Future Directions for Policy and Practice

Western Capitalist societies are characterised by a competitive and hierarchical individualistic structure. Failure to compete successfully and the absence of friendship networks can lead to an experience of being socially denigrated or humiliated and endangers the identity of human beings. This is leading to demands for ‘the right to be esteemed and recognised’, particularly for those feeling vulnerable in such a society [7].

A symptom of this is a huge rise in the incidence of depression and other psychosocial problems. Seventy years ago depression as we know it was too rare to be properly researched [28]. Today almost a quarter of the population reports some experience of mental ill health, the vast majority reporting depression and/or anxiety. 30% of initial consultations at a GPs surgery are for depression or anxiety and this increases to 50% of subsequent consultations. Well over 60% of people attending GPs surgeries for such psychosocial problems are sympathetically turned away as distressed, but not ill. But what fuels this demand for services? Many GPs in a study undertaken by Shaw [21] stated that patients were looking for a ‘quick fix’ or a ‘magic bullet’ or tablet that would make them happy. This is also the background to the massive growth of the ‘psy-industries’ of counselling and psychotherapy as the traditional coping mechanisms of the church, the community and family have been eroded. One could also argue that this is the context behind the huge rises in drug and alcohol abuse in contemporary society. People are ‘buying into’ such services in search of happiness and self-fulfilment, but such services can only reconcile people to ‘what is’ and in doing so also renders self-identity dependent upon those professionals. There is certainly a great danger in just assuming a compensatory function through contact with therapists. This would serve to reify the notion of friendship and community support (by equating it with a particular type of emotional support only). Whereas individualised therapy cannot replace the friendship and support which are part of ad hoc social networks that are often culturally specific and which form a part of our social identity.

The belief that the defining feature of ‘the self’ is its vulnerability informs much of the psychology of Western cultures. In this context ‘recognition of the self’ implies acknowledging the condition and experience of vulnerability. For the individual, the disclosure of vulnerability has the status of a moral statement that invites social and cultural affirmation. It encourages the establishment of suffering as a measure of social virtue. That is why, with a decline of friendship networks, it has become common for some people to define themselves through a psychological or medical diagnosis [7,29].

The rise of ‘therapeutic demand’ which has arisen from a breakdown of solidarity and community is becoming manifest in a number of areas. For example research on stress at work has argued that the massive increase in work related stress is related to the breakdown of trade unionism and collective means of solving work related problems [30], 2002. As trade union actions became unacceptable problems became expressed through a bio-medical idiom. Since the 1980s a more individuated workplace ethos has fostered a climate where problems are readily medicalised. At a time of existential insecurity, a medical diagnosis at least has the virtue of definition. A disease both explains an individual’s behaviour and helps to ratify a sense of identity. In other words, the medicalisation of everyday life allows individuals to make sense of their predicament and gain moral sympathy. It also represents a socially sanctioned claim for recognition. As a consequence there is a demand from people to

expand diagnosis in medicine to recognise their situation (eg ME, Attention Deficit Disorder, Gulf War Syndrome, Post-Traumatic Stress Disorder, RSI as well as anxiety and depression). In doing this people are 'relieved of responsibility' for their behaviour as they gain recognition. It is a search for identity and a valorisation of a person's individual difference through the claim for therapeutic status - because therapy is seen as a vehicle to social affirmation. The argument is that people are driven by a deep psychological need to be recognised and affirmed and that some seek identity and recognition in this way because they may not have the friendship or community networks to otherwise achieve this in a competitive individualistic society. In the absence of friendship and community networks, therapy becomes a vehicle for such recognition. It is, however, ironic that their identity may then become attached to its own social exclusion because it is attached to social exclusion for its very existence as identity [29]. Building on the argument above some commentators have concluded that psychological therapies are themselves problematic [7,29] and while we would agree with this in relation CBT; we would argue that those psychological therapies developed from an existential and humanistic theoretical framework offer exactly the forms of help that are needed. Rather than an illness ideology which is subject to the criticisms outlined above, these therapies need to offer a different paradigmatic view of what it is to be human, how distress arises and how it is best dealt with [31]. Rather than concern with hedonic well-being their focus is on eudaimonic well-being and helping people to make meaning in their lives in such a way that recognises that distress arises not from biochemical abnormalities but from problems that have their roots in distal social causes [32]. Rather than offering interventions based on diagnosis and treatment for so called psychiatric disorders these therapies disown the illness ideology and instead offer a relational focus.

Increasingly, it is recognised that it is the qualities of the therapeutic relationship rather than the techniques employed that is helpful [33-36]. This is not in an attempt to replace missing social networks but because it is understood that in non-threatening empathic relationships, people are able to examine their own situations non-defensively and work out the best solutions to their own problems. As such, existential and humanistic therapies, specifically person-centred therapies [37], deliberately set out to promote the agency of the client.

While recognising that the therapeutic industry has a role to play and that there are psychological therapies consistent with our sociological analysis because of their deliberate focus on the agency of the client, we return to the main argument that people's problems in living are not best addressed reactively if the cause ultimately resides in distal social factors. As such, we would argue that as well as enhancing the availability of psychological therapies to help people once their problems of unhappiness have developed it would be logical to address issues before they arise. A first step to achieving happiness and improving mental health in society may be to try and re-establish the anchors of community in people's everyday lives ('Connecting' is one of NEFs 5 ways to wellbeing [17]) and dealing with the socio-economic inequalities that give rise to mental distress. This would beg a wider range of questions such as what are the various ways in which social networks provide support functions and what may be missing in an individual's life and then what is it that therapy can offer? To answer this question we can turn to recent developments in positive psychology which have shown that well-being arises in circumstances where people have their basic psychological needs met. Building on Maslow's original work on needs, it is now widely accepted that people have basic psychological needs for autonomy, competence, and

belonging [38,39]. When these needs are met, psychological well-being can be achieved.

In conclusion, we have argued that before any attempt is made to try and 'compensate' for breakdowns in friendships and social networks that one should consider the various aspects of friendship in order to try and specify what one would aim to achieve in terms of therapy. Therapies such as person-centred therapy that actively address peoples' problems from an understanding that their mental distress is a result of their basic psychological needs not being met are potentially valuable. However, even such therapies as these only serve to condone the inequalities and injustices that give rise to mental distress in the first place if they are implemented instead of social change [40]. Thus, rather than waiting to address problems reactively, we need to understand how public policy serves to either facilitate or undermine peoples' basic psychological needs in order to proactively prevent mental distress from arising in the first place.

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