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Words

A proposal to classify happiness as a psychiatric disorder

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Author's abstract

It is proposed that happiness be classified as a psychiatric disorder and be included in future editions of the major diagnostic manuals under the new name: major affective disorder, pleasant type. *In a review of the relevant literature it is shown that happiness is statistically abnormal, consists of a discrete cluster of symptoms, is associated with a range of cognitive abnormalities, and probably reflects the abnormal functioning of the central nervous system. One possible objection to this proposal remains – that happiness is not negatively valued. However, this objection is dismissed as scientifically irrelevant.*

Introduction

Happiness is a phenomenon that has received very little attention from psychopathologists, perhaps because it is not normally regarded as a cause for therapeutic concern. For this reason, research on the topic of happiness has been rather limited and any statement of existing knowledge about the phenomenon must therefore be supplemented by uncontrolled clinical observation. Nonetheless, I will argue that there is a *prima facie* case for classifying happiness as a psychiatric disorder, suitable for inclusion in future revisions of diagnostic manuals such as the American Psychiatric Association's Diagnostic and Statistical Manual or the World Health Organisation's International Classification of Diseases. I am aware that this proposal is counter-intuitive and likely to be resisted by the psychological and psychiatric community. However, such resistance will have to explain the relative security of happiness as a psychiatric disorder as compared with less secure, though established conditions such as schizophrenia. In anticipation of the likely resistance to my proposal I will therefore preface my arguments with a brief review of the existing scientific literature on happiness. Much of the following account is based on the work of Argyle (1).

It is perhaps premature to attempt an exact definition of happiness. However, despite the fact that formal diagnostic criteria have yet to be agreed, it seems likely that happiness has affective, cognitive and behavioural components. Thus, happiness is usually characterised by a positive mood, sometimes described as 'elation' or 'joy', although this may be relatively absent in the milder happy states, sometimes termed 'contentment'. Argyle, in his review of the relevant empirical literature, focuses more on the cognitive components of happiness, which he describes in terms of a general satisfaction with specific areas of life such as relationships and work, and also in terms of the happy person's belief in his or her own competence and self-efficacy. The behavioural components of happiness are less easily characterised but particular facial expressions such as 'smiling' have been noted; interestingly there is evidence that these expressions are common across cultures, which suggests that they may be biological in origin (2). Uncontrolled observations, such as those found in plays and novels, suggest that happy people are often carefree, impulsive and unpredictable in their actions. Certain kinds of social behaviour have also been reported to accompany happiness, including a high frequency of recreational interpersonal contacts, and prosocial actions towards others identified as less happy (3). This latter observation may help to explain the persistence of happiness despite its debilitating consequences (to be described below): happy people seem to wish to force their condition on their unhappy companions and relatives. In the absence of well-established physiological markers of happiness, it seems likely that the subjective mood state will continue to be the most widely recognised indicator of the condition. Indeed, Argyle has remarked that 'If people say they are happy then they *are* happy' (4). In this regard, the rules for identifying happiness are remarkably similar to those used by psychiatrists to identify many other disorders, for example depression.

The epidemiology of happiness has hardly been researched. Although it seems likely that happiness is a relatively rare phenomenon, exact incidence rates must depend on the criteria for happiness employed in any particular survey. (In this respect happiness is also not unique: similar problems have been encountered when attempts have been made to investigate the

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epidemiology of other psychiatric disorders such as schizophrenia (5)). Thus, although Warr and Payne (6) found that as many as 25 per cent of a British sample said that they were 'very pleased with things yesterday', Andrews and Withey (7), studying a large US sample, found that only 5.5 per cent of their subjects rated themselves as scoring maximum on a nine-point scale of life-satisfaction. One problem with these kinds of data is that they have been generated in the absence of good operational criteria for happiness and have focused on the cognitive components of the condition (perhaps because these are comparatively easy to measure) rather than the affective and behavioural components. It is therefore quite possible that informal observation is a better guide to the prevalence of happiness in community samples. Certainly, if television soap operas in any way reflect real life, happiness is a very rare phenomenon indeed in places as far apart as Manchester, the East End of London and Australia. Interestingly, despite all the uncertainty about the epidemiology of happiness, there is some evidence that it is unevenly distributed amongst the social classes: individuals in the higher socio-economic groupings generally report greater positive affect (8) which may reflect the fact that they are more frequently exposed to environmental risk-factors for happiness.

Further light might be shed on the nature of happiness by considering its aetiology. Although the cause or causes of happiness have yet to be identified aetiological theories have implicated both environmental and biological factors. With respect to the environment, there seems little doubt that discrete episodes of happiness typically follow positive life-events (9). However, the observation that some people are generally happier than others suggests that less transient factors may also play an important role. While it has been suggested that a general disposition towards happiness is related to self-esteem (10) and social skills (1), two variables which presumably reflect early learning experiences, the finding that extroversion is a good predictor of happiness even years in the future (11) suggests that biological factors may be implicated.

Evidence that happiness is related to cognitive abnormalities will be outlined below when I discuss the proposition that happiness is irrational. Genetic studies of happiness are a neglected avenue of research but neurophysiological evidence points to the involvement of certain brain centres and biochemical systems. Thus, stimulation of various brain regions has been found to elicit the affective and behavioural components of happiness in animals (12) as has the administration of drugs which affect the central nervous system such as amphetamine and alcohol (13). Taking the environmental and biological evidence together it may be necessary to discriminate between various different types of happiness. Thus, it may be useful to distinguish between *reactive happiness*, usually manifesting itself as an acute episode followed by a rapid remission of symptoms, and *endogenous happiness* which may have a relatively chronic onset and which may be less often followed by symptomatic improvement. The differential diagnosis of these two types of happiness is an obvious project for future studies. Given the apparent similarities between happiness and depression, it seems possible that endogenous happiness will be characterised by positive mood first thing in the morning, a heavy appetite, and persistent erotomania.

Happiness as a psychiatric disease

Since the emergence of the profession of psychiatry in the nineteenth century it has commonly been assumed that psychiatric disorders are forms of disease. Whilst this assumption has not gone unchallenged in recent years (14) it remains so pervasive within the mental health professions that the demonstration that happiness qualifies as a disease would be a powerful argument for including it within future nosologies of psychiatric disorder.

Historically, there have been two approaches towards the definition of disease (15). The first, which is best exemplified by the work of the doctor Thomas Sydenham in the eighteenth century, involves the identification of syndromes consisting of clusters of symptoms that occur together. The second, which is best exemplified by the later work of Virchow, involves the identification of a pathological process that is causally implicated in a disturbance of body or behaviour. In practice, medical scientists usually hope that the two types of classification will converge to enable the generation of causal models of disease. However, for most psychiatric disorders this prospect lies somewhere in the future (16). For this reason, when considering the evidence that happiness is a disease, it will be useful to bear in mind for comparison the evidence pertaining to the disease status of recognised psychiatric disorders such as schizophrenia.

The question of whether or not it is possible to identify a meaningful syndrome of happiness has been the subject of only very limited research. According to Argyle (1), most investigators agree that happiness is best thought of as a dimension of affect, rather than as a discrete category of emotional disequilibrium: in this respect at least happiness appears to be similar to both schizophrenia and perhaps the majority of psychiatric disorders (17). However, the relationship between the dimension of happiness and other affective dimensions remains unclear. Thus, in a factor-analytic investigation (8) it was observed that reports of happiness and reports of negatively valued affective states loaded on separate factors, suggesting that they are independent of each other. Interestingly, people who report high-*intensities* of happiness also report high intensities of other emotions (18), which might be regarded as evidence for the hypothesis (to be discussed below) that happiness is related to a neurophysiological state of disinhibition. Nonetheless,

the *frequencies* with which people report happiness and the negatively valued affective states appear to be negatively correlated (19). Some confusion also exists about the relationship between happiness and the psychiatric disorder of mania; although it might be expected that these are related conditions Argyle (1) has noted that mania, in contrast to happiness, is mainly characterised by excitement. Nonetheless, the diagnostic criteria for hypomanic episodes employed by the American Psychiatric Association (20) seem to allow happiness to be regarded as a subtype of hypomania. Taking all this evidence together, it might be argued that there is only modest empirical support for the notion of a discrete happiness syndrome. On the other hand, the evidence is really quite favourable when compared with the evidence supporting other widely accepted psychiatric syndromes such as schizophrenia (21).

Some evidence that happiness is related to a disturbance of the central nervous system has already been noted. Just as it is possible to elicit schizophrenic symptoms in some individuals by stimulating the parietal lobes, so too it is possible to produce happiness by brain stimulation, though of subcortical centres (12). Cortical centres also seem to be implicated however, as both left hemisphere seizures and right hemispherectomy have been associated with prolonged euphoric states; indeed it has been suggested that emotional states in general are regulated by a complex balance of excitatory and inhibitory centres in both hemispheres, and that abnormal affective states of any kind reflect a disturbance of this balance (22). Clearly, further biological research is needed to specify in any detail the role of neuropsychological abnormalities in happiness but a promising start has been made, and quite a clear picture is apparent in comparison to the mixed results of nearly one hundred years of research into schizophrenia (21).

Indeed, it is the lack of progress in identifying a biological pathology for schizophrenia and other psychiatric disorders that has led some authors to reject the notion that schizophrenia is a disease (14) and others to argue that the criteria for disease should not require the identification of an underlying biological pathology (23). Clearly, if, as I have argued, happiness meets the narrower criteria for disease employed in physical medicine it is also likely to meet any such broader criteria advocated for psychiatry. For example, it has been suggested that, for the purposes of psychiatric research, a disease be simply regarded as any deviation from the norm by way of excess or deficit which confers upon the sufferer some form of biological disadvantage (24). Evidence that happiness is statistically abnormal has already been discussed and, despite the lack of clear data, there is at least some reason to suppose that happiness confers a biological disadvantage, at least in the short term. Consistent clinical evidence of an association between happiness, obesity and indulgence in alcoholic beverages has existed from before the time of scientific medicine (Julius Caesar, for example, is reputed to have asked for the company of fat men on these grounds (24)). Given the well-established link between both alcohol and obesity and life-threatening illnesses it seems reasonable to assume that happiness poses a moderate risk to life. The common observation that happiness leads to impulsive behaviour is a further cause for concern.

More clear evidence that happiness confers a biological disadvantage can be discerned from the literature relating various cognitive measures to mood state, but before discussing this evidence it will first be useful to consider the proposition, advocated by some philosophers, that *irrationality* rather than disease be considered the criterion for psychiatric disorder.

Happiness, irrationality and cognition

Mainly because of persisting doubts about the value of applying the concept of disease to psychiatric disorders, a number of philosophers have suggested that the quality of *rationality* is the most appropriate criterion for distinguishing between such disorders and types of behaviour and experience not worthy of psychiatric attention. According to Radden (26), behaviour may be described as irrational if it is bizarre and socially unacceptable, reduces the individual's expected utilities, or is not grounded on good (ie logically consistent and acceptable) reasons; in the latter case, in particular, Radden believes that the behaviour should be the subject of psychiatric scrutiny. A similar view has been taken by Edwards (27) who claims that *bona fide* cases of psychiatric disorder are characterised by actions that fail to realise manifest goals, thinking that is illogical and replete with contradictions, beliefs that should be falsified by experience, the inability to give reasons for actions, unintelligible or nonsensical thinking, and a lack of impartiality and fairmindedness.

Some definitions of irrationality clearly make more sense than others. Bizarreness and social disapproval are weak criteria for irrationality because they are culturally constrained and difficult to apply with any consistency: the Lancastrian's predilection for dried pig's blood may seem bizarre to the Hotentot, who prefers to eat slugs. Against this, some authors have argued that delusional beliefs should be tested against their cultural background, although this has the disadvantage of allowing totalitarian regimes to diagnose political dissidents as insane (28).

In testing whether or not happiness is irrational it may therefore be safer to fall back on the other approaches to defining irrationality outlined by Radden and Edwards. Thus, although there is a lack of relevant data, it seems reasonable to assume that happiness often results in actions which fail to realise manifest goals, and which therefore decrease the happy person's expected utilities. The potentially life-threatening consequences of happiness have already been discussed. In addition, happy people may experience great difficulties when faced with mundane

but essential tasks.

Both Radden and Edwards imply that irrationality may be demonstrated by the detection of cognitive deficits and distortions of one sort or another. There is excellent experimental evidence that happy people are irrational in this sense. It has been shown that happy people, in comparison with people who are miserable or depressed, are impaired when retrieving negative events from long-term memory (29). Happy people have also been shown to exhibit various biases of judgement that prevent them from acquiring a realistic understanding of their physical and social environment. Thus, there is consistent evidence that happy people overestimate their control over environmental events (often to the point of perceiving completely random events as subject to their will), give unrealistically positive evaluations of their own achievements, believe that others share their unrealistic opinions about themselves, and show a general lack of evenhandedness when comparing themselves to others (30). Although the lack of these biases in depressed people has led many psychiatric researchers to focus their attention on what has come to be known as *depressive realism* it is the unrealism of happy people that is more noteworthy, and surely clear evidence that such people should be regarded as psychiatrically disordered.

Possible objections

I have argued that happiness meets all reasonable criteria for a psychiatric disorder. It is statistically abnormal, consists of a discrete cluster of symptoms, there is at least some evidence that it reflects the abnormal functioning of the central nervous system, and it is associated with various cognitive abnormalities – in particular, a lack of contact with reality. Acceptance of these arguments leads to the obvious conclusion that happiness should be included in future taxonomies of mental illness, probably as a form of affective disorder. This would place it on Axis I of the American Psychiatric Association's Diagnostic and Statistical Manual (20). With this prospect in mind, I humbly suggest that the ordinary language term 'happiness' be replaced by the more formal description *major affective disorder, pleasant type*, in the interests of scientific precision and in the hope of reducing any possible diagnostic ambiguities.

There are two possible objections to the proposed inclusion of major affective disorder, pleasant type, as a psychiatric disorder. First, it might be argued that happiness is not normally a cause for therapeutic concern. Therapeutic concern has in fact been proposed as a criterion for disease by Kraupl-Taylor (31) because of the difficulties of formulating a less arbitrary criterion. However, Kendell (15) has criticised this definition as worse than no definition at all because of its obvious circularity and because of the inevitable implication that diseases are culturally and historically relative phenomena. On this account, sickle-cell anaemia, anorexia nervosa and psychopathy (to name but three unequivocal examples of disease described only in recent times) were not diseases before their discovery. In any event, once the debilitating consequences of happiness become widely recognised it is likely that psychiatrists will begin to devise treatments for the condition and we can expect the emergence of happiness clinics and anti-happiness medications in the not too distant future.

The second, related objection to the proposal that happiness be regarded as a psychiatric disorder points to the fact that happiness is not normally negatively valued. Indeed, it is testimony to the insidious effects of happiness on some of the greatest minds in history that some philosophers have argued that the pursuit of happiness is the ultimate aim of all human endeavours. However, it is notable that even some of those who have been rash enough to advocate the greatest happiness for the greatest number have been explicit in rejecting those extreme forms of happiness associated with gluttony of the senses (32). More importantly, the argument that happiness be excluded from future classifications of mental disorder merely on the grounds that it is not negatively valued carries the implication that value judgements should determine our approach to psychiatric classification. Such a suggestion is clearly inimical to the spirit of psychopathology considered as a natural science. Indeed, only a psychopathology that openly declares the relevance of values to classification could persist in excluding happiness from the psychiatric disorders.

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