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From the Editor's desk

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Life, liberty and the pursuit of happiness

In 1972, the King of Bhutan proposed a new way of assessing national success through a happiness philosophy for successful societies.[1] The policies that ensued aimed to address the formidable development challenges facing Bhutan, a small and relatively poor country with low levels of education, high infant mortality, a relatively low life expectancy, with multiple social adversities and a geographical terrain that made it difficult to establish easy and rapid connections between people in different parts of the country. Educational, agricultural, social and health policies were all seen as part of a collective that needed a harmonised response. This bold proposition adopted ancient Eastern philosophies, Buddhism among others, that hold that material wealth is not as relevant and can be an illusory distraction on the path to happiness and a good life. Thus, gross domestic product (GDP) was deemed less relevant than Gross National Happiness (GNH), and the programme of national development attempted to spread national wealth across society, preserve cultural traditions, protect the environment and maintain a responsive government.[2] Although this inspired higher-income countries, where wealth and productivity were clearly not resulting in happiness, the relational and collective nature of happiness, and the importance of social justice, addressing poverty and inequalities, safety and mutual dependency, have to some extent been lost in translation.[3]

Following the trend to seek better metrics for societal success, in the higher-income countries a language of well-being has emerged. The relationship between health, well-being and happiness are central to health and social policy. The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being; mental health is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (http://www.who.int/features/factfiles/mental_health/en/). There is now a greater emphasis on the individual rather than on collective well-being. This risks losing sight of the relational and socially embedded fabric of happiness. This psychologisation and individuation of well-being clearly gives the concept utility in modern high-income economies, where addressing unemployment and poor health are seen as priorities. However, this individuation of well-being further alienates contemporary policies and practices from the original source of the concepts, and perhaps corrupts the essential elements of well-being and happiness initiatives. Economists are also critical of the value of indices of well-being or even happiness as measures of progressive societies that serve all equally.[4] The Chief Medical Officer's report on public mental health cautioned against an over-interpretation of well-being as a buffer against or a remedy to mental illness, proposing more research and evidence as the foundation for future policy and practice.[5]

Many of the assertions or actions suggested to promote happiness and well-being may be seen as political solutions in the remit of local and national government actions outside of healthcare, yet healthcare is a deeply political issue as is evident around elections of national governments. New evidence is now emerging of more nuanced critiques of well-being and its relationship with health and illness. Community participation was linked to better mental well-being a year later, independent of baseline levels of mental well-being.[6]

Two seminal papers in this month's *BJPsych* provide new evidence to help us navigate the relationship between well-being and mental health. Kinderman *et al* (pp. 456–460) show that interventions aimed at maximising well-being and interventions aimed at preventing or treating mental illness are complementary but distinct. Rumination is reported to be associated with a three-fold greater risk of developing anxiety or depression following negative life events; people who lacked adaptive coping skills were three times more likely to have low subjective well-being in the face of social deprivation; however, these two pathways were independent of each other. Stewart-Brown *et al*'s paper (pp. 461–465) shows that the risks for low but not high mental well-being mirror those for mental illness. This suggests that the socioeconomic factors associated with mental health are not the same as those associated with mental illness, so reinforcing the need to be careful when proposing interventions that are aimed at improving well-being (or happiness) versus those aimed at preventing or treating mental illness.

Also in this issue, we find that fatherhood does not necessarily involve poor mental health consequences (Leach *et al*, pp. 471–478) and religiosity does not always confer protection against suicide (O'Reilly & Rosato, pp. 466–470). Psychosis is a disabling condition which is rare in young people (Tiffin & Kitchen, pp. 517–518), requiring early intervention and prolonged specialised treatment (Chang *et al*, pp. 492–500) for the best outcome. Cognitive restructuring is helpful for people with post-traumatic stress disorder and severe mental illness, with better outcomes than education and anxiety management (Mueser *et al*, pp. 501–508). Two studies help us stratify people by treatment responsiveness: adverse effects of clozapine are more likely in those with 22q11.2 deletion (Butcher *et al*, pp. 484–491), and those with the most extensive cortical thinning on brain imaging have the most disabling negative symptoms (Nenadic *et al*, pp. 479–483). Topical new areas for research include the use of social media to reduce stigma (Betton *et al*, pp. 443–444) and the place of forensic in-patient care (Barbui & Saraceno, pp. 445–446); and the role of de-escalation training to reduce violence is contested (Price *et al*, pp. 447–455). Professionals continue to work towards high-quality, safe and evidence-based care that takes account of inequality and poverty. Alongside this, we need political action that is evidenced and that targets stigma and extreme social and health inequalities such that life, liberty and happiness are realistic aspirations for people living with mental illness.

1 Zurick D. Gross national happiness and the environmental status in Bhutan. *Geographical Rev* 2006; **96**: 657–81.

2 Revkin AC. A new measure of well-being from a happy little kingdom. *NY Times* 4 October 2005 (http://www.nytimes.com/2005/10/04/science/04happ.html?pagewanted=all&_r=0).

3 Knifton L. Collective wellbeing in public mental health. *Perspect Public Health* 2015; **135**: 24–6.

4 Kahneman D, Deaton A. High income improves evaluation of life but not emotional well-being. *Proc Natl Acad Sci USA* 2010; **107**: 16489–93.

5 Davies SC. Public mental health: evidence based priorities. In *Annual Report of the Chief Medical Officer 2013*. Department of Health, 2014.

6 Ding N, Berry HL, O'Brien LV. One-year reciprocal relationship between community participation and mental wellbeing in Australia: a panel analysis. *Soc Sci Med* 2015; **128**: 246–54.