

In search of Happiness: Health, quality of life, and sociability¹

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Abstract

Health and well-being – topics that have been widely discussed – are the focus of this essay based on studies of people with mental disorders. The relevant literature indicates that people with greater density of social ties and more active social life are more satisfied and feel happier. They show more self-assurance when making decisions, present fewer health problems, and are even more sexually fulfilled. Their level of well-being varies; some manage to face their illness with fewer ill effects, and therefore are more resilient, what can be explained by several factors: psychological factors, physical condition, and above all access to a comfortable environment of sociability, where they can receive support and comfort, and have space to develop as a person

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Introduction

What is it that makes people happier? What are the ingredients most conducive to well-being? These questions relate to the concept of good life, which – in general terms – means feeling comfortable in the world, having a satisfactory condition of life. Such a condition might encompass numerous factors: physical well-being (state of health, having a healthy body), mental well-being (a state of tranquillity, with one's mind at peace and free of worries), and social well-being (having a place in a social environment that provides recognition, welcomes, and permits a reasonable degree of success in personal projects). Attaining well-being, then, includes both personal and collective efforts: the opportune use of the resources life offers to individuals and to society. A set of quite complex factors is involved, which includes even the role played by different conceptions of happiness, such as: valuing pleasures offered by life; search for perfection through a frugal life based on spiritual illumination; or simply satisfying the basic needs of existence. As can be seen, a gamut of reasons and discursive constructions underlie the production of a grammar of happiness, strongly influenced by the vicissitudes of civilisation. Both humankind and society are meant for happiness; according to some authors, this depends on three basic principles: (a) the fulfilment of a purpose of one's own; (b) the moral and political dimension, taking not just the individual into account, but

his/her relation to others; and (c) the means necessary to attain happiness (Caillé et al., 2003, p.16)

Health and well-being are topics that we will explore in this essay, showing that greater well-being – and thus greater capacity to cope with one’s condition – is linked to several factors that, taken together, indicate a more active social life. Therefore, maintaining social ties, and even creating new ones, is fundamental to any therapeutic project for people with a mental disorder.

Mental health and society: models to explain the social factors causing the worsening or improvement of mental condition

The concept of health has received innumerable discursive constructions in different historical contexts and civilisations, leading to a range of grammars of what constitutes well-being in terms of health and disease. The first point to consider is the special meaning of disease as against the more general concept of illness. While the latter refers to an individual's belief that something internal is disrupting his/her well-being, thus something that may be explained in medical terms, sickness refers to causes, a known aetiology of what caused the discomfort. Clearly, since the birth of the modern epoch, concepts of disease and illness have been directly linked to a medical discourse, within practices that, though arising from techniques of listening, seek to explain the symptoms of illness in biological terms (Foucault, 1975). Nonetheless, this biomedical foundation is not always the dominant influence on the construction of an aetiology. In the past, the patterns defining states of sickness were organised through other discourses and

practices, including practices of self-care – the way people coped with their condition. In some societies, for example, practices of cure were the province of shamans, who organised a series of rituals which that community believed in: “It does not matter that the mythology of the Shaman does not correspond to an objective reality: the sick person believes in him, and he is a member of a society that also believes” (Lévi-Strauss, 1991, p.228).

However, there is no one exclusive system of cure, though a preponderant system can normally be observed. As we have seen, modern societies base their classification of diseases (and so a system of healing practices) on a biomedical orientation; but other practices, known as alternative or complementary, exist alongside it, which are often growing in importance. They possess distinct discourses and their own aetiological models, and employ specific techniques. Besides this complex, diverse discourse, we should also not forget those discursive constructions supported by a magical and religious narrative: diseases and situations of discomfort may be interpreted as disorganised states of the spirit. These latter are especially important for discursive constructions of mental health.

Besides biomedical considerations regarding the state of health, what the literature terms “social determinants of health” are essential. When so defined, the phenomenon of mental disease is not fully explained by biomedical indices alone. Though it may be possible to describe some symptoms as the result of organic changes, a universal consensus has long since formed that environmental factors play a decisive role in the production of mental disturbance; in other words, the social conditions associated with

poverty, unemployment, violence, the absence of public health services, and other factors. Thus, the general conditions of life produce pressures that often aggravate the individual's mental suffering, particularly in the case of low income populations.

In the case of mental health, this is particularly obvious insofar as the recognised markers of an aetiology of mental disease are not as clear as in other medical specialisms. There are therefore no clinical medical procedures to establish a precise or definitive diagnosis. Thus, as Eaton (2001, p.12) affirms, “In the disease model, the pathological process or its consequences are often observable with instruments like a microscope or modern radiological imaging device. In the specialty of psychiatry many important brain and/or social processes are too subtle in their manifestations to be observed, at least with current technology”.

Mental disturbance is preponderantly defined by behavioural characteristics; these in turn are strongly inscribed in the definition of the boundary between what is socially acceptable (patterns of behaviour considered to be “normal”) and what, in that specific social environment, is held to be inappropriate. In sociological terms, mental disturbance is defined in terms of behaviours that bear three characteristics: (a) loss of control over the environment; (b) distancing from social ties; and (c) interference with the perception of meaning in an individual's biography (Eaton, 2001, p.52). To sum up, still following Eaton, disturbance is marked by bizarre emotions and “disabling” emotions.

As we have seen, mental disturbance derives from a complex set of factors, and these are frequently inscribed in different, or even competing discursive fields. For example, the precursors of

modern psychiatry, Pinel and Esquirol, advocated the “moral hygiene” method, according to which techniques of moral re-education were used to free people with a disturbance from the vices and deleterious influences of the environment, which caused their sickness². Castel (1976, p.93) describes Pinel’s therapeutic approach thus: “First imposition of order: to isolate from the outside world, to break with the source of uncontrolled influences from which, he believed, the illness sustained its own disorder; this is the justification for the notorious *therapeutic isolation*”. The medical literature often brings into question the efficacy of explanatory models based solely on traditional procedures of aetiological explanation (Heinz, 2014). Some authors go so far as to denounce the fragility of psychiatric models precisely because of their failure to consider social factors in the explanation of mental disturbance, for example, Scheff (1968), Aneshensel (2005) and Townsend (1980).

Polysemy is thus attested in the semantic field of mental health in both academic and lay traditions. These discursive spaces can clearly be seen to include the assertion of a link between mental disturbance and social order. In contemporary social literature, for example, a series of studies connected to the Chicago school can be highlighted; these blame the disorganised state of major cities for the imbalances and neuroses of their inhabitants. Classic studies such as Simmel’s (1995) on “The metropolis and the life of the mind” underlie the reflections of these researchers of the Chicago school. Another classic text is that of Wirth (1938),

² Later on, this practice was strongly opposed, because of the consequences of asylum life for patients’ sociabilities. See Goffmann (1966) on this subject.

who warns of the implications of urban growth for the way people behave. Many other studies followed, such as Mower (1970) on urban ecology and mental disorders, Faris and Dunham (1970) on mental disorders in urban areas, Queen (1970) on mental disorders and urban ecology published together in Pierson's (1970) collection on human ecology. Along the same lines, Ehrenberg (1998) proposes a "*réajustement du Moi*", whereby it would fit in with modern urban reality, with its agitated life and inebriating sensations.

More recently, researchers have suggested that mental disturbances may also arise from the characteristics of the civilisation of this new century, which are not the same as those experienced by Freud, which gave rise to neuroses. Ehrenberg (1998) proposes a genealogy of suffering, in which neurosis arises as a reopening of the purely psychical wound with its origin in a traumatic event. These occurrences, once again according to Ehrenberg (2012), are typical of the "*mal du siècle*" as seen in sociabilities experienced at the end of the nineteenth century. Neurosis is therefore typical of modern times.

Depression and melancholy, concepts already employed at the beginning of the twentieth century, have been resignified in this new century. Anchors such as guilt, discipline and obedience, which served to keep desiring subjects from attaining full realisation, have now been shifted to the new era's demands for performance: in the workplace, in sexual life, in friendships, in short, performance is the *deus ex machina* of this new civilisation. Authors such as Han (2015) have proposed the Society of Exhaustion, af-

firming that neuroses also constitute the malaise of this new century, the twenty-first, as opposed to those of an immunological type (the infections) characteristic of the twentieth century; a clear distinction is drawn between the interior (the psyche) and the exterior (bacteria, viruses, what comes from outside).

The fundamental hypothesis of studies that take account of social factors to explain mental disorders is that there exist symptoms which cause the illness while at the same time protecting the individual to some extent from its effects, or cushioning them. The central concepts used to explain why some victims of mental disorders are more *resilient* than others are the terms *stress* and *buffer*. Among risk factors for sickness, epidemiological studies thus include those of a social nature alongside the traditional factors inscribed in the sphere of the individual (Link & Phelan, 1995); other studies present an epidemiology of social stress, making explicit that differences in exposure to stress can explain socio-demographic variation in mental health (Turner & Lloyd, 1999). Similarly, cushioning factors – that stimulate greater resilience – are emphasised. For instance, Jackson (1992) shows the important relation between support and buffering factors.

But empirical studies go further than this. On the hypothesis that sickness or a worsening of the pattern of illness are also a result of social factors, various researchers have focused on specific points within the general range of social determinants of health, some seeking to identify populations shown to be more vulnerable, those whose position within social structure leaves them more exposed to stress factors; several studies show that questions of gender, race, and generation need to be taken into account. Others

analyse factors that cushion people against sickness, including many showing that belonging to denser social circles provides individuals with access to resources that are a significant source of support in coping with the suffering caused by mental disorders. A very wide range of resources (material, emotional, those resulting from positive social interactions, information, among others) are attained through relations established by individuals in everyday life. As we can see, the topic of social support has been exhaustively studied.

Literature in this area includes various studies that attempt to determine social causes for sickness, though without precisely indicating what are the most important factors. For example, they simply show that depression is associated with socio-economic status (Eaton, 2001a; Kessler & Cleary, 1980; Ulbrich et al., 1989) with accumulated traumas in the life histories of individuals (Turner & Lloyd, 1995; Ensel & Lin, 1991); or that there is a strong association between social stratification and mental disorders (Aneshensel, 2009; Pearlin, 1989). Some of these studies, rather than being based on empirical research, merely comment on the relevant literature, or propose hypotheses for new avenues of investigation. While social scientists seem to agree unanimously that social factors are important determinants of mental health, a large part of the academic community also agrees that the complexity of this phenomenon makes it hard to measure.

Researchers have made a considerable effort to establish clearer relationships between social conditions and sickness. On the assumption that inequalities produced by social structure offer

people different opportunities, and that this differentiation also results in a corresponding variation in levels of stress, the position of certain groups within social structure will expose them to more stressful situations and make them more likely to become sick. This pattern has been studied in various contexts, including: infant mortality (Andrade et al., 2006; Assis et al., 2007), ethnicity (Barata et al., 2007), breast cancer (Dias-da-Costa, et al., 2007), access to education (Gomes, Araújo Jr., & Salvato, 2006), anaemia (Assunção et al., 2007), heart disease (Ishitani et al., 2006). Such stress factors are also linked to race; for example, Afro-Americans have social networks to provide social support, but they are strongly affected by negative social interaction, and this makes depressive symptoms more likely to appear (Lincoln et al., 2005). Other ethnic minorities such as migrants are equally affected by the symptoms of stress, both through negative social interactions and because of difficulties in cultural adaptation. One example is the North Korean immigrant community in Toronto, Canada (Noh & Avison, 1996).

Everyday adversities are also experienced by population groups besides ethnic communities, because of their disadvantaged position within social structure, such as their gender. Single mothers, for instance, face day-to-day difficulties that may sometimes result in illness. These are people in relatively vulnerable situations without the support of a partner in childrearing and housekeeping. They consequently have higher rates of disorder than those living with another adult (Thompson & Ensminger, 1989). More female adolescents than male show symptoms of depression. Avison and McAlpine (1992) explain the difference in terms of higher self-esteem on the part of the boys than the girls,

which is a clear indication of differences in the process of socialisation. Some other noteworthy studies point out the importance of gender issues in explaining some stress factors that encourage mental illness: Umberson and colleagues (1996) analyse gender differences to see how the form and quality of these relationships affect the psychological state of men and women differently; Newman (1986) comments on gender differences in patterns of vulnerability and stress; Mirowsky and Ross (1995) investigate why women show depressive symptoms more frequently. This literature clearly provides ample material to show that gender differences are an important marker for explaining the incidence of mental disorders.

The literature also has much to say on the performance of social roles, which may sometimes lead to problems. For instance, young people confront stressful events during their student careers (Jackson & Finney, 2002) or more generally in the context of their involvement in multiple fields of sociability such as family and school friends (Kaplan et al., 1983; Newcomb et al., 1981). These factors do not seem to amount to precise causes, but they do generate greater stress in the performance of activities required in daily life. A similar phenomenon in the context of relationships within the family occurs when conflicts that have arisen may lead to divorce, which is well known as a stress factor that causes depressive symptoms (Menaghan & Lieberman, 1986). Again, differences between spouses may reflect gender imbalances that can be a major factor in creating stress (Thoits, 1987).

The literature also includes a series of empirical studies showing the existence of factors that protect people from traumatic everyday events so they are less likely to become sick or else, if a disorder does occur, they can cope with it more effectively with fewer ill effects in terms of well-being. Thus, such people enjoy better quality of life, and, consequently, are happier. When studying factors that cushion people from suffering or which may, in some cases, lead to increased capacity to cope with adversity, the key phenomenon is basically social support. Social support refers to resources that are brought into play from the ego-centred network: people seek help from their family, friends, work colleagues, members of their religious congregation, anyone they know.

We must also consider that those with mental disorders may cope with their suffering better if they meet with support and help from the people they know; moreover, those who share their suffering – father, mother, spouse, friend – and care for them may make their own lives easier to bear if they offer each other assistance in support groups where they can share the challenges of human misery.

There are two important questions here. First, studies of social support deal directly or indirectly with relational phenomena. Sources of support are located in the fabric of individuals' network, that is, the social circles within which they move. Such a network-based approach has been receiving increasing attention from social scientists, and it allows new types of analysis. For example, Brughha (2006) compares the range of resource opportunities mobilised by more extensive networks and networks that are primary in charac-

ter; Donati (1994, p.217) suggests that the pattern of health is influenced by the existence and characteristics of social networks; and Gottlieb (1985, p.297) explains how networks affect treatment by reducing the risk of a worsening in the pattern of stress.

Secondly, there is a series of studies looking at the effects of social support on particular experiences of people affected by an illness, or those close to them. Studies describing the mechanisms of social support amongst people who have had cardiac surgery (Rankin & Monahan, 1991), adolescents (Nath et al., 1991), people with hearing loss (Frankel et al., 1983), pregnant teenagers (Turner et al., 1990) show the effects of social support in people's everyday lives. For those affected by mental disturbance, resources derived from sociability by means of support may mean greater comfort for those suffering from the illness as well as those living close to them, who may themselves suffer ill effects (carers often need to be cared for). In such cases, participation in support groups makes a great difference, significantly diminishing the care burden (Cook et al., 1999; Greenberg et al., 1997). Swapping experiences of the often-painful everyday reality of living with and caring for sufferers can bring very significant benefits for all parties.

Finally, there are certain methodological issues. How should social support be studied? In such studies, information about social support is generally sought from those who receive resources from their networks. The information given by respondents about help received is based on their own perceptions of its importance. Clearly, people's perceptions of the world do not themselves constitute reality; they reflect a subjective evaluation, and may depend on several factors. For instance, people undergoing a depressive

crisis tend to view reality more pessimistically than average. Feelings of rejection, stigma or other negative forms of social interaction are also perceived subjectively according to people's characteristic outlook. Practically all studies on support are founded on measures of representation constructed on ordinal scales. These are subject to numerous validity tests underpinned by well-defined research protocols. Nonetheless, questions such as validity and reliability always arise.

Another important factor is the complexity of treatment for people with a mental disturbance, generally implying a chronic condition, as noted by White and colleagues (2005). In other words, though a cure may be, strictly speaking, impossible, with no symptoms, recovery is: being able to live with the illness as acceptable levels of quality of life are recovered. Defined in this way, the process can be understood in full when several factors are considered: examples include multidisciplinary programmes for mental health assistance (Farkas et al., 2005), social support (Hendryx et al., 2009), and religion (Heller & Gitterman, 2011).

Any discussion of recovery implies a consideration of well-being. From the 1970s on, several studies appeared that looked for markers of perceived well-being. This information would help in understanding how people live with their condition, or even help establish which questions are important for people when they are asked about the “good life”.

Studies on well-being are closely related to those on social support, but unlike the latter, they seek markers of well-being, “the idea that certain circumstances are required for high quality of life in all cultures and for all individuals” (Tay & Diener, 2011: 354).

In other words, what factors should be considered when evaluating quality of life? Diener approaches this question in various articles (Diener & Scollon, 2014; Diener et al., 2014; Diener, 2013; Diener et al., 2013), which seek to pin down concepts such as happiness and subjective well-being. There are also many studies that attempt to validate measures of well-being. Where they try to establish reasonably clear criteria for these terms, which are, as we have seen, polysemic, there is generally also an effort to construct instruments to measure them. There is thus an extensive literature, with some texts proposing measures for well-being, for example, Perez-Truglia (2015), who indicates parameters for scale validation tests for happiness and life satisfaction; or Bericat (2014), who indicates validation criteria for the Socioemotional well-being index; Diener and Inglehart (2013), who analyse validation procedures for scales of Life Satisfaction. Others survey the latest literature, for example Tay and colleagues (2013), who aim to “summarize current evidence on social relations and health” – that is, what are the central questions for scholars of well-being, and how important are social relations as a variable.

Another major question is the extent to which these representations of happiness and well-being possess universal ingredients characteristic of human nature rather than being specific constructs characterising each culture. At the beginning of this article we sought to show the presence of notions such as the good life or happiness at various points in the history of humankind, which would make the attempt to satisfy one's desires an ingredient characteristic of human beings as such. This topic has been thoroughly

explored by researchers on well-being, who show through comparative studies that although cultural differences cannot be ignored, there are factors which are present universally. Diener (2013) attempts to show the importance of the relation between income and well-being; Tay and Diener (2011) use a sample of people from 123 countries to investigate the association between the fulfilment of needs and subjective well-being; Longhi (2014) compares various ethnic groups living in the United Kingdom to assess the importance of cultural diversity for people's life satisfaction; Chen and colleagues (2015) attempt to show that certain basic psychological needs are important for an explanation of well-being, using studies of Belgian and Chinese adolescents.

Finally, it should also be emphasised that some studies of well-being focus on people with mental disorders. Unlike those centred on the concept of social support, they investigated how people with disorders cope (or not) with the various problems their illness entails for quality of life. On the topic of the relation between well-being and life satisfaction, there are studies by Bao and others (2013) on mental health and life satisfaction, with Chinese adult participants; Vasquez and others (2015) investigate the differing impacts of physical and mental illness on life satisfaction among Spanish adults; Palmer and others (2014) study people living with schizophrenia.

As can be seen, there is an extensive well-being agenda embracing a series of questions. Scales to measure well-being show a range of validation problems that remain unresolved by researchers. Studies of mental disturbance reflect still greater problems, since, often, the perception of well-being may be complicated by

people's cognitive difficulties, which tend to become more severe to the extent the illness is chronic.

Conclusions

Reviewed literature shows that, while biological and indeed psychological factors should certainly not be discounted, it is certain that people who have a more active social life are better able to cope with their illness and, therefore, they are happier. We are convinced that any therapeutic practice must consider these questions, in order to obtain better results in the quality of life of people with mental disorders.

This is the case, for instance, of the Brazilian experience, as seen in the service provided by the CAPS (Psychosocial treatment centres). The CAPS arose as part of the Brazilian psychiatric reform (Law 10.216, 6th April 2001), which proposes alternatives to the hospital-centred approach. This model strives to orient its therapeutic practice according to certain principles: (a) social reinsertion: the person with a mental disorder achieves higher life quality by maintaining an active social life; (b) medical procedures are needed at times of crisis; in such cases the patient should be treated in a general hospital, free of the power structure inscribed in the asylum; (c) therapeutic approaches should be developed in a multidisciplinary environment including diverse visions of insanity; (d) family and community (through diverse associations) are important in facing mental disorder (Fontes, 2010, p.366).

We believe that the therapeutic practices employed by the CAPS team, the emphasis on integrating the person with the disturbance within the territory and the recovery of their ties of sociability, play an important role in the feeling of well-being experienced by a large proportion of these suffering individuals.

While biological and indeed psychological factors should certainly not be discounted, it is certain that people who have a more active social life are better able to cope with their illness and therefore they are happier. These are people cared for by a multi-disciplinary team – among others, psychiatrists, psychologists, social workers, nurses. The practice of the CAPS therapeutic project aims to consider the active social life of those in its care as an ingredient fundamental for the success of treatment. This approach aims to meet the deficits in traditional approaches primarily focussed on biomedical elements. A comparative study might well be of interest, but the fact is that differing sociabilities are seen in these people's biographical trajectories even though they are undergoing the same therapeutic procedure. In some cases, this can be explained by the type of disorder, but in others there is no such direct association with their diagnosis. The fact is that richer sociabilities imply improved perception of well-being. Again, in this case we have not asked what it is that activates sociabilities; we simply note the relation between sociability and quality of life.

Another important theme within research on mental health and sociability relates to the phenomenon of social support. Empirical studies have sought to explain how people manage to bear their suffering more easily leaning on practices of sociability inscribed in their networks. The development of illness leads to the

erosion of social ties, as shown in our study (Fontes, 2010), which also demonstrated that the sociability network structures of the population we observed are important tools for the mobilisation of resources, thus making it possible for people with mental disturbances to cope better with their psychological suffering. We showed an important relationship between satisfaction with health and sociability. People with larger networks cope more easily with their suffering and stigma. This leads us to conclude that more solid structural forms of sociability are fundamental to constructing a healthy life, confronting the effects the erosion of social ties have on people with a mental disturbance; for them, these are devastating.

In this essay we have shown that numerous studies demonstrated that people with greater density of ties (a more active social life), and propitious socioeconomic circumstances are more satisfied and feel happier. This contentment, translated into well-being, is indicated by several psychological and even physical factors: these are people who have more self-assurance when faced with a decision, or who have fewer health problems. Clearly, these are the perceptions of people who face problems of reduced quality of life caused by the pattern of their illness, the side-effects of the medication taken on a regular basis, and the stigma and consequent rejection arising from their label of being a “mentally ill” person. Their level of well-being varies; some manage to face their condition with fewer ill-effects, and consequently they are more resilient, as can be explained by a series of factors: psychological factors,

physical condition, and above all their access to a comfortable environment of sociability where they can receive support and comfort, and have space to develop as a person.

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