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COMPLETE MENTAL HEALTH: AN AGENDA FOR THE 21ST CENTURY

COREY L. M. KEYES

Congress passed the National Mental Health Act in 1946, which provided substantial funding for psychiatric research and education, and created the National Institute of Mental Health (NIMH; see Mechanic, 1989). From its inception, the NIMH's mission and modus operandi has been "To improve this nation's mental health . . ." by supporting ". . . a wide range of research related to the etiology, diagnosis, treatment, and prevention of mental *disorders*" (U.S. Department of Health and Human Services, 1995, p. 1; emphasis added). Although the mission of improving the mental health should continue, this chapter will argue that the practice of doing so by focusing solely on mental illness must be amended to include an equal emphasis on mental health.

Despite more than 50 years of national commitment to mental health, very little has been learned about it. Instead, much has been learned about mental illness, which is a persistent and substantial deviation from normal functioning that impairs an individual's ability to execute their social roles (e.g., employee) and generates emotional suffering (Spitzer & Wilson, 1975). Depression, in particular, costs billions each year through lost productivity, health care costs, and premature mortality from suicide (Keyes & Lopez, 2002; Murray & Lopez, 1996; Mrazek & Haggerty, 1994; Rebellon, Brown, & Keyes, 2001; U.S. Department of Health and Human Services, 1998). Studies suggest that about 1 in 10 adults have an episode of major depression each year, and 5 in 10 adults experience at least one serious mental illness

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in their lifetime (Kessler et al., 1994; Robins & Regier, 1991, U.S. Department of Health and Human Services, 1999).

Though mental illness is prevalent, the statistics also suggest that many people do not "breakdown." About one half of the adult population will be free of serious mental illness throughout life, and about 90% will not experience major depression each year. Are these adults who remain free of mental illness necessarily mentally healthy? This is a paramount question for proponents of the mental health model who view mental health as a state that is not merely the absence of mental illness (Keyes, 2002; Ryff & Singer, 1998). According to the surgeon general, mentally healthy adults have *successful* mental function, *fulfilling* relationships, *productive* activities, and the *capacity for adaptation* (U.S. Department of Health and Human Services, 1999). This definition embraces the idea that mental health is the presence of positive levels of feelings and psychosocial functioning and not simply the absence of mental illness (see also Jahoda, 1958; Smith, 1959; World Health Organization, 1948).

The purpose of this chapter is to review the conception and diagnosis of mental health. Research is reviewed that clearly shows that there are grave reasons for concern about the mental health of adults in the United States. First, fewer than one quarter of adults between the ages of 25 and 74 fit the criteria for *flourishing* in life, which is defined as a state in which an individual feels positive emotion toward life and is functioning well psychologically and socially. Second, individuals diagnosed as flourishing have excellent emotional health, miss fewer days of work, cut back on work on fewer days, and have fewer physical limitations in their daily lives.

Third, the absence of mental health—a condition described as *languishing*—is more prevalent than major depression disorder. Languishing is defined as a state in which an individual is devoid of positive emotion toward life, is not functioning well psychologically or socially, and has not been depressed during the past year. In short, languishers are neither mentally ill nor mentally healthy. Languishing is a "disorder" that exists on the mental health continuum (see Keyes, 2002), constituting a life of quiet despair that parallels clinical accounts of patients who may describe their lives as "hollow" or "empty" (see, e.g., Cushman, 1990; Levy, 1984).

Fourth, languishing is associated with emotional distress and psychosocial impairment at levels that are comparable to the impairment associated with a major depressive episode.

In sum, there are compelling reasons that positive psychologists cannot overlook mental illness. However, languishing—a silent and debilitating epidemic in the United States—indicates that there are equally compelling reasons that behavioral and social scientists can no longer ignore the concept of mental health. This chapter begins with the current and historic conceptions of mental health, with special emphasis on the absence of mental

health. Neither the surgeon general's definition of mental health nor historical accounts of positive mental health (e.g., Jahoda, 1958) have addressed the nature of the absence of mental health, and accounts of languishing stretch back through history.

THE ABSENCE OF MENTAL HEALTH

Languishing in Life

The Eighth Deadly Sin

To the ancients, and particularly Christian philosophers like Evagrius Ponticus, the state of languishing was the eighth deadly sin (Funk, 1998; Sutera, 1999). Acedia vanished from the list of deadly sins in the 6th century at the hands of Pope Gregory the Great. Derived from the Greek term *akdeia*, which denotes indifference, the concept of acedia denotes the absence of care and is similar to states of apathy and ennui. Acedia is spiritual sloth and physical idleness, which reasons the early Christians deemed it sinful. *The Oxford English Dictionary* (1991) defines acedia and languishing synonymously. Acedia is "sloth, torpor," and a "condition leading to listlessness and want of interest of life." Languishing is defined as "Suffering from, or exhibiting, weariness or ennui," and as "failing to excite interest" in life.[1]

Arrest of Life

Count Leo Tolstoy described what could only be considered a form of languishing in his autobiographical work titled, "A Confession." At the age of about 50, and at the height of his literary success, Tolstoy wrote the following account of his life:

> At first I experienced moments of perplexity and arrest of life, as though I did not know what to do or how to live; and I felt lost and became dejected. But this passed, and I went on living as before. Then these moments of perplexity began to recur oftener and oftener, and always in the same form. They were always expressed by the questions: What is it for? What does it lead to? At first it seemed to me that these were aimless and irrelevant questions. I thought that it was all well known, and that if I should ever wish to deal with the solution it would not cost me much effort; just at present I had no time for it, but when I wanted to, I should be able to find the answer. The questions however began to repeat themselves frequently, and to demand replies more and

[1]Thanks to Dr. Greg Fricchione, director of the Carter Center's mental health program, for the suggestion of *Acedia* as the historical equivalent of languishing.

> more insistently, and like drops of ink always falling on one place they ran together into one black blot. (1882/1951, pp. 15–16)[2]

Tolstoy's moments of perplexity and dejection, inquiries about the purpose and meaning of life, and his comparison of the feelings as amounting to "one black blot" of ink suggests a person tormented by the absence of feeling for life rather than the presence of negative feelings toward life. Indeed, Tolstoy describes how the feelings of despair and emptiness occurred at a time of "complete good fortune." He characterized his life as consisting of a good wife, good children, and a large estate. He continued, "And far from being insane or mentally diseased, I enjoyed the contrary strength of mind and body . . . mentally I could work for eight and ten hours at a stretch. . . . " (pp. 18–19).[3]

Something More

There are contemporary accounts of languishing in life that parallel Tolstoy's confessions of emptiness. For example, the October 13, 1998, "Oprah Winfrey Show" was devoted to the topic of women's lives and wanting something more out of life. The backdrop for this discussion, however, was women's struggle with languishing in life.

The women who spoke clarified the meaning and challenge of languishing in life. These women had the trappings of success—good marriages, great children, good jobs, and nice homes in good neighborhoods. Yet these women clearly suffered from very low well-being. They felt empty, lost, lacking a purpose, and adrift without meaning in life ("The Oprah Winfrey Show," 1998, pp. 1–2).

These women described social conditions that should lead to the absence of mental disorders—in other words, married, employed, a good home, and healthy children. However, the feelings and functioning described by these women illustrate the conception of languishing in life. They described themselves as having unsettling feelings, a void in their souls. They attempted to fill the void with hedonistic pursuits that did not quench their desire for meaning, and pondered such ultimate questions as the purpose and meaning of life.

The Lost Children of Rockdale County

Between 1996, as the state of Georgia and city of Atlanta prepared to host the Olympics, and May 20, 1999, a series of events occurred in

[2] Reprinted by permission of Oxford University Press.
[3] Thanks to Dr. George Vaillant for the suggestion that Tolstoy was one of history's greatest languishers.

Rockdale County that reflected, in part, a social void and personal emptiness in youth. A 16-year-old boy was killed in a fight at a strip-mall parking lot. An adolescent boy, wielding a shotgun, went on a shooting rampage at Heritage High School (in Conyers, Georgia, May 20, 1999) wounding six fellow students. Moreover, 17 teenagers in Rockdale County between the ages of 14 and 17 tested positive for syphilis, and 200 teenagers were exposed to the sexually transmitted virus. The story of Rockdale County's "lost children" is one of economic prosperity and personal emptiness (cf. Myers, 2000).

Rockdale County is small and affluent, and comprises mostly Caucasian, suburban, and middle-class and upper-class families. The children of Rockdale lived physically comfortable, somewhat privileged lives. Heritage High School, where the shooting and several of the syphilis cases occurred, was ranked among the best schools in Georgia. However, the public health investigation of the syphilis outbreak unveiled a story of group sex, alcohol abuse, and drug use among the teenagers. Documented by Public Broadcasting's *Frontline* series and analyzed by the pundits, explanations for Rockdale County included the theme of languishing. *Frontline's* producer of the "Lost Children of Rockdale County," Rachel Dretzin Goodman, said that she and her colleagues "came to see the syphilis outbreak in Rockdale County as a kind of metaphor for a deeper malady afflicting so many adolescent today. Wherever we went, we met kids who were drifting, hungry for something to fill the void left by too much time on their own and too little structure in their lives."[4]

The absence of structure in the lives of Rockdale's youth was ironically a reflection of their parent's economic success. The parents were successful, busy, and hard-working individuals. These parents could therefore provide for their children's material needs but had little time or energy leftover to provide for their teenager's existential needs. Commenting on children's natural craving for attention, a former school guidance counselor in the Rockdale system, Peggy Cooper, noted how the absence of attention is particularly troubling for youth. She said that children naturally crave attention and "they'll get good attention as long as they can get it. If they can't get good attention, they'll get bad attention because the worst thing in the world to them is to have no attention. No attention is to lead a solitary life" (Frontline, 2002).[5] According to Michael Resnick, a professor of sociology and pediatrics at the University of Minnesota,

[4]Information and all quotations in this section are taken from the transcript of the Frontline documentary and the postscripts available on the Georgia Public Television's Lost Children of Rockdale County Webpage (www.pbs.org/wgbh/pages/frontline/shows/georgia). Retrieved July 15, 2002. Used by permission.
[5]Quoted by permission.

> It certainly wasn't clear who was the more lost: the children or the parents of Rockdale County. . . . We heard a lot about emptiness. Houses that were empty and devoid of supervision, adult presence, oversight. There was in far too many of the adolescents a fundamental emptiness of purpose; a sense that they were not needed, not connected to adults, to tasks, to anything meaningful other than the raw and relentless pursuit of pleasure. (Frontline, 2002)[6]

What do the youth of Rockdale County, living life at the end of the 20th century in the affluence of the United States, share in common with the ancient notion of acedia or Tolstoy's confessions of his want for meaning in life? Whether sinning with a slothful soul or seized by questions of life's purpose, individuals have languished throughout history. People suffer a quiet despair that comes from the absence of meaning, the absence of purpose, and the absence of anything positive in life. Languishing is an overlooked malady that is the counterpart to mental health. Although languishers are stagnant and empty, flourishing individuals have an enthusiasm for life and are actively and productively engaged with others and in society.

MENTAL HEALTH OPERATIONALIZED

Symptoms and Syndrome

Mental health, like mental illness, should be viewed as a syndrome of symptoms. A state of health, like illness, is indicated when a set of symptoms at a specific level are exhibited for a period of time that coincides with distinctive mental and social functioning (Mechanic, 1999). The symptoms of mental health consist of an individual's subjective well-being. Subjective well-being reflects individuals' perceptions and evaluations of their own lives in terms of their affective states and their psychological and social functioning. Forty years of research on subjective well-being has yielded a taxonomy of mental health symptoms consisting of emotional well-being and functional well-being (Keyes, Shmotkin, & Ryff, 2002; Keyes & Waterman, 2003).

Emotional well-being is a cluster of symptoms reflecting the presence and absence of positive feelings about life (see Table 13.1). Symptoms of emotional well-being can be ascertained from individuals' responses to structured scales measuring the presence of positive affect (e.g., individual is in good spirits), the absence of negative affect (e.g., individual is not

[6]Quoted by permission.

TABLE 13.1.
Operational Definitions of Symptoms of Mental Health

Positive feelings: emotional well-being	Positive functioning: psychological well-being	Positive functioning: social well-being
Positive affect: Regularly cheerful, in good spirits, happy, calm and peaceful, satisfied, and full of life.	*Self-acceptance*: Positive attitude toward oneself and past life, and concedes and accepts varied aspects of self.	*Social acceptance*: Positive attitude toward others while acknowledging and accepting people's complexity.
Happiness: Feels happiness toward past or about present life overall or in domains of life.[a]	*Personal growth*: Insight into one's potential, sense of development, and open to challenging new experiences.	*Social actualization*: Cares and believes that, collectively, people have potential and society can evolve positively.
Life Satisfaction: Sense of contentment or satisfaction with past or present life overall or in life domains.[a]	*Purpose in life*: Has goals, beliefs that affirm sense of direction in life, and feels life has purpose and meaning.	*Social contribution*: Feels that one's life is useful to society and that one's contributions are valued by others.
	Environmental mastery: Has capability to manage complex environment and can choose or create suitable environs.	*Social coherence*: Has interest in society, feels it's intelligible, somewhat logical, predictable, and meaningful.
	Autonomy: Comfortable with self-direction, has internal standards, resists unsavory social pressures.	*Social integration*: Feels part of, and a sense of belonging to, a community, derives comfort and support from community.
	Positive relations with others: Has warm, satisfying, trusting relationships, and is capable of empathy and intimacy.	

[a]Examples of life domains are employment, marriage, and neighborhood.

hopeless), and perceived satisfaction or happiness with life. Measures of the expression of emotional well-being in terms of positive affect and negative affect are related but distinct dimensions (e.g., Bradburn, 1969; Watson & Tellegen, 1985). Last, measures of avowed (e.g., "I am satisfied with life") and expressed (i.e., positive and negative affect) emotional well-being are related but distinct dimensions (Andrews & Withey, 1976; Bryant & Veroff, 1982; Diener, 1984; Diener, Sandvik, & Pavot, 1991; Diener, Suh, Lucas, & Smith, 1999).

Ryff (1989) argued that well-being is more than happiness with life. In addition, subjective well-being includes measures of positive functioning in life. Since Ryff's (1989) operationalization of clinical and personality theory conceptions of positive functioning (Jahoda, 1958), the field has moved toward a broader set of measures of psychological well-being. Positive functioning consists of six dimensions: self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery, and autonomy (see Keyes & Ryff, 1999). Individuals are mentally healthy when they like all parts of themselves, have warm trusting relationships, see themselves developing into better people, have a direction in life, are able to shape their world to satisfy their needs, and have a degree of self-determination. The psychological well-being scales are reliable and validated (Ryff, 1989); the hypothesized six-factor structure has been confirmed in a large and representative sample of U.S. adults (Ryff & Keyes, 1995).

Keyes (1998) argued that positive functioning consists of more than psychological well-being. Functioning well in life includes social challenges and tasks that reflect an individual's social well-being (Keyes, 1998). Whereas psychological well-being represents more private and personal criteria for the evaluation of functioning, social well-being epitomizes the more public and social criteria whereby people evaluate their functioning in life. These social dimensions consist of social coherence, social actualization, social integration, social acceptance, and social contribution. Individuals are mentally healthy when they view social life as meaningful and understandable, when they see society as possessing potential for growth, when they feel they belong to their communities, are able to accept all parts of society, and when they see their lives as contributing to society. The social well-being scales have shown good construct validity and internal consistency, and the hypothesized five-factor structure has been confirmed in two studies of representative samples of adults in the United States (Keyes, 1998; Keyes & Shapiro, in press).

Diagnosis of Mental Health

Empirically, mental health and mental illness are not opposite ends of a single continuum. Measures of symptoms of mental illness (viz., depression) correlate modestly and negatively with various measures of subjective well-being. Specifically, measures of psychological well-being (in two separate studies reviewed in Ryff & Keyes, 1995) correlated on average −.51 with the Zung depression inventory and −.55 with the Center for Epidemiological Studies depression (CESD) scale. Indicators and scales of life satisfaction and happiness (i.e., emotional well-being) also tend to correlate around −.40 to −.50 with scales of depression symptoms (see Frisch, Cornell, Villa-

nueva, & Retzlaff, 1992). In short, there is about 25% shared variance between common scales of depression and subjective well-being.

Confirmatory factor analyses of the subscales of the CESD and the scales of psychological well-being in a sample of U.S. adults supported the two-factor theory (Keyes, Ryff, & Lee, in press). That is, the best-fitting model was one in which the CESD subscales were indicators of the latent factor that represented the presence and absence of mental illness. The psychological well-being scales were indicators of a second latent factor that represented the presence and absence of mental health. These findings corroborate factor analyses that showed that measures of life satisfaction and positive affect loaded on a separate factor from measures of anxiety and depression (Headey, Kelley, & Wearing, 1993). Thus, studies reveal that mental health is not merely the absence of mental illness symptoms, nor is it simply the presence of high levels of subjective well-being.

The measures of subjective well-being shown previously in Table 13.1 fall into two clusters of symptoms. Whereas measures of emotional well-being comprise a cluster that reflects symptoms of emotional vitality, measures of psychological well-being and social well-being reflect a cluster of symptoms of positive functioning. Both clusters of mental health symptoms mirror the cluster of symptoms used in the *DSM-III-R* (American Psychiatric Association, 1987) to diagnose a major depressive episode (MDE). That is, depression consists of symptoms of depressed mood (e.g., or anhedonia: loss of pleasure derived from activities) and symptoms of malfunctioning (e.g., insomnia or hypersomnia). Of the nine symptoms of MDE, a diagnosis of depression is made when a respondent reports five or more symptoms (at least one symptom must be from the depressed mood cluster).

The diagnosis of states along the mental health continuum is based on the *DSM-III-R* (American Psychiatric Association, 1987) approach for major depression. In the study by Keyes (2002), respondents completed a structured scale of positive affect and an item on life satisfaction. Respondents also completed the six scales of psychological well-being and five scales of social well-being. Altogether, the study included two symptom scales of emotional vitality and 11 symptom scales of positive functioning (i.e., six psychological, five social, well-being). To be diagnosed as *languishing* in life, individuals must exhibit low levels (low = lower tertile) on one of the two scales of emotional well-being and low levels on six of the 11 scales of positive functioning. To be diagnosed as *flourishing* in life, individuals must exhibit high levels (high = upper tertile) on one of the two scales of emotional well-being and high levels on six of the 11 scales of positive functioning. Adults who are *moderately mentally healthy* are neither flourishing nor languishing in life. Individuals who are languishing or flourishing must therefore exhibit, respectively, low or high levels of emotional vitality and

positive functioning on at least 50% or more of the symptom scales. As with the diagnosis of major depression, the symptoms of emotional vitality are considered essential for the diagnosis of mental health insofar as individuals must exhibit either a high level of satisfaction or a high level of positive affect.

In sum, mental health should be viewed as a complete state consisting of two dimensions: the mental illness continuum and the mental health continuum. As shown in Figure 13.1, each dimension respectively ranges from a high to a low level of symptoms of mental illness and mental health. When both dimensions are crossed together, two states of mental illness and three states of mental health emerge. Individuals who are flourishing in life are completely mentally healthy because they are not only free of major depression, they also fit the diagnostic criteria for the presence of mental health. Individuals who fit the criteria for moderate mental health and for languishing have incomplete mental health; although these individuals are not depressed, they do not have sufficiently high levels of well-being to fit the criteria for mental health. In turn, there are individuals with incomplete mental illness such as those who fit the *DSM* criteria for major depression but who have at least moderate or even higher levels of subjective well-being. Although such individuals may have other comorbid mental illnesses, they are classified as having a "pure" episode of mental illness,

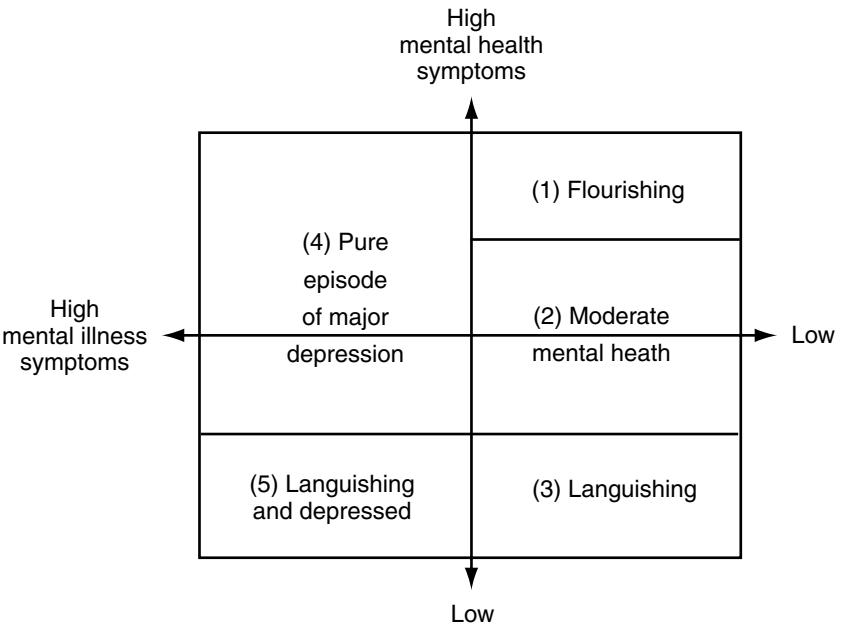

Figure 13.1. The complete mental health model and diagnostic categories.

because they are not also languishing in life. Last, individuals who fit the criteria for major depression and for languishing have complete mental illness, because they are mentally ill *and* devoid of mental health.

MENTAL HEALTH IN THE UNITED STATES

Findings From the Study of Midlife in the United States

The Midlife in the United States (MIDUS) study comprises a nationally representative sample of 3,032 adults between the ages of 25 and 74. This study was conducted in 1995 by an interdisciplinary team of scholars convened and supported by the John D. and Catherine T. MacArthur Foundation to study successful aging and human development (see Brim, Ryff, & Kessler, in press). MIDUS is an exemplary study for many reasons, two of which are relevant to this chapter. First, MIDUS used structured *DSM-III-R* categories (American Psychiatric Association, 1987) to diagnose mental illness. MIDUS used the Composite International Diagnostic Interview Short Form scales (CIDI-SF; Kessler, Andrews, Mroczek, Ustun, & Wittchen, 1998), which has shown excellent diagnostic sensitivity and specificity compared with diagnoses based on the complete CIDI in the National Comorbidity Study (Kessler, DuPont, Berglund, & Wittchen, 1999). During the telephone interview that was part of the research, the CIDI-SF was used to assess whether respondents exhibited symptoms indicative of MDE during the past 12 months. Second, the MIDUS measured the emotional, psychological, and social well-being of adults. Thus—using the mental health diagnosis described earlier—MIDUS permits the investigation of languishing and flourishing in comparison with *DSM* diagnoses of mental illnesses. What follows is based on MIDUS and research reported in Keyes (2002).

Mental Health: Prevalence and Comorbidity

Most adults, 85.9%, did not have a depressive episode. However, only 21.6% of adults fit the criteria for flourishing in life. More than half of the sample (i.e., 58.7%) had moderate mental health, and nearly 20% of adults fit the criteria for languishing in life. Cross-tabulation of the depression diagnosis and the mental health diagnosis revealed a strong dose–response relationship. About 5% of flourishing adults and 13% of adults with moderate mental health had a depressive episode in the past year. However, 28% of languishing adults had major depression during the past year. Thus, moderately mentally healthy individuals were two times more likely than flourishing adults to have had a depressive episode; languishing adults were five

times more likely than flourishing adults and two times as likely as moderately mentally healthy adults to have had a depressive episode.

The combination of depression and mental health diagnoses permitted the assessment of the complete mental health status of respondents. Of the 14.1% of adults who had a depressive episode, 9.4% had a pure episode of depression (i.e., incomplete mental illness),[7] and the remaining 4.7% of depressed adults were also languishing (i.e., completely mentally ill). Of the 85.9% of nondepressed cases, 56.6% were moderately mentally healthy, 17.2% were completely mentally healthy (i.e., flourishing), and 12.1% had incomplete mental health (i.e., pure languishing).

Mental Health: Psychosocial Functioning

Respondents were asked to evaluate their "mental or emotional health" on a scale from "poor," "fair," "good," "very good," to "excellent." Figure 13.2 reveals that the diagnosis of complete mental health corresponds with individuals' self-reported mental, emotional health. More than half of the adults who were languishing and had an episode of depression evaluated their emotional health as "poor" or "fair." In contrast, fewer than 1% of flourishing and just under 6% of adults with moderate mental health said their emotional health was "poor" or "fair." However, almost 18% of adults with a pure languishing (i.e., languishing but not depressed) and 22% of adults with pure depressive episode (i.e., depressed but not languishing) saw their emotional health as "poor" or "fair."

Almost all of the flourishing adults and more than half of adults with moderate mental health felt that their emotional health was "very good" or "excellent." In contrast, only a third of adults with pure languishing and a third of adults with pure depression felt that their emotional health was "very good" or "excellent." Only 15% of adults who were languishing and had a depressive episode saw their emotional health as "very good" or "excellent." Conversely, more than half of the adults who languished and had depression said their emotional health was "poor" or "fair." Nearly as many adults with pure languishing—about one third—as those with pure depression said their emotional health was "poor" or "fair." Less than 6% of adults with moderate mental health and less than 1% of flourishing adults said their emotional health was "poor" or "fair."[8]

[7] Of the 14.1% depressed adults, 0.9% were also flourishing and 8.5% were also moderately mentally healthy.

[8] The association of mental health with perceived emotional health was unchanged in multivariate models that include adjustment for a host of sociodemographic variables (i.e., sex, age, race, education, marital status, employment status).

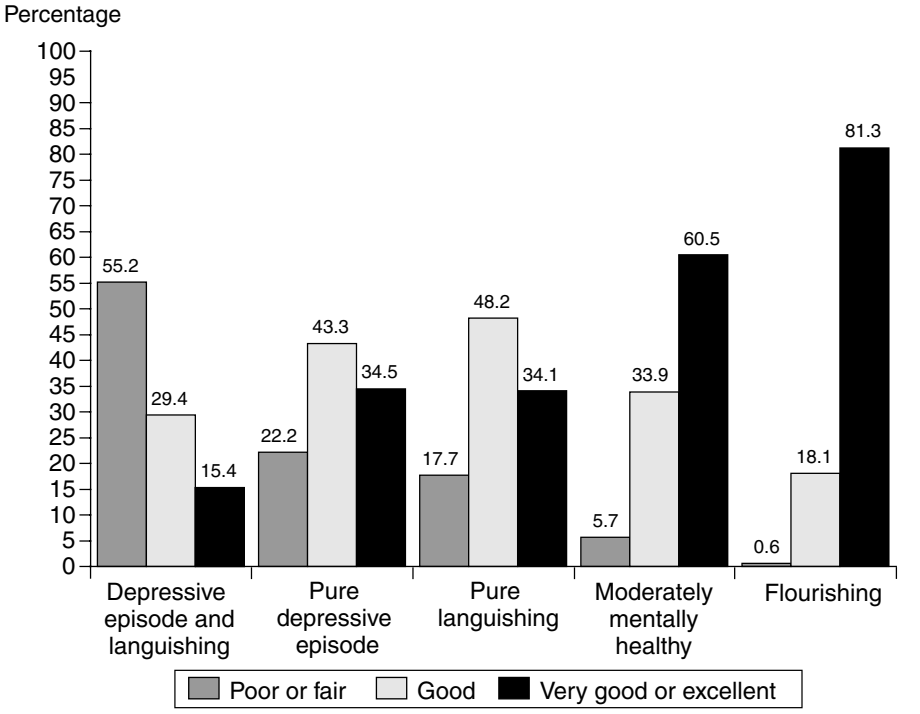

Figure 13.2. Self-rated mental, emotional health by major depressive episode and mental health status.

Respondents also evaluated how much their health limited them from doing any of nine instrumental activities of daily life. The activities included such things as lifting and carrying groceries, climbing several flights of stairs, walking several blocks, and moderate activity such as vacuuming. The analysis focused on whether a respondent reported at least one activity that was limited "a lot" by their health, which denoted a "severe" limitation. Nearly 70% of adults who were languishing and had a depressive episode had at least one severe limitation, whereas 64% of adults with pure languishing had at least one severe limitation. About 55% of moderately well and 55% of individuals with pure depression had at least one severe limitation. Only 42% of flourishing adults reported at least one severe limitation. Thus, flourishing adults also appeared to be the most physically healthy subpopulation. However, more adults with pure languishing showed signs of physical health problems than adults with pure depression. By comparison, almost three quarters of adults who were languishing and had a depressive episode showed signs of physical health problems.

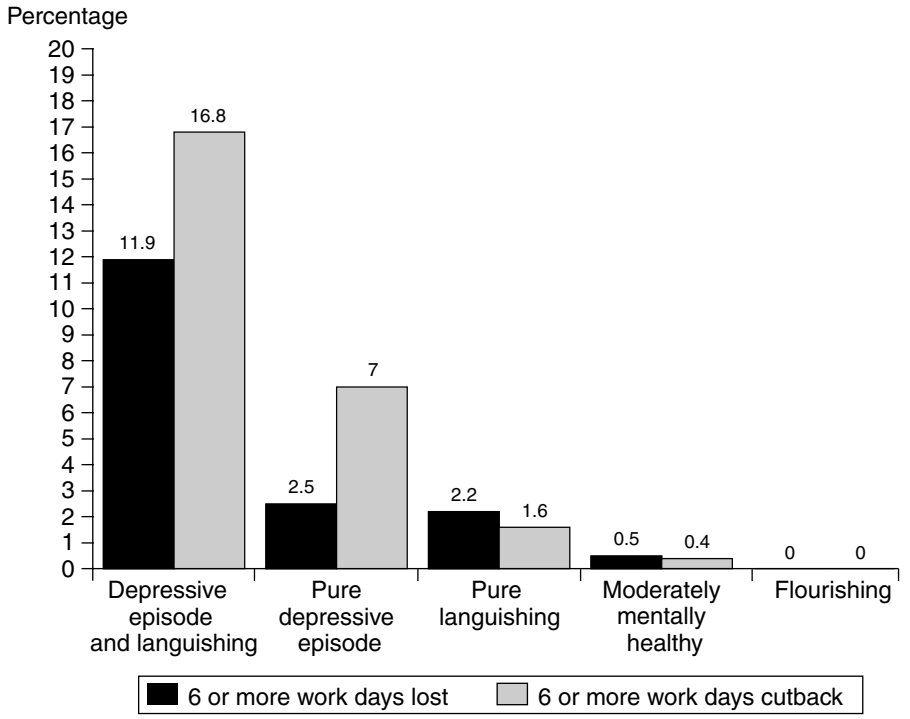

Figure 13.3. Severe work impairment over past 30 days by major depressive episode and mental health status.

Data were collected regarding the number of days of work in the past 30 days individuals either cut back on the work they could get done or were completely unable to go to work or carry out normal household activities (i.e., days of lost work). Follow-up questions assessed whether the work cutbacks and lost days of work were a result of problems with physical health, mental health, or a combination of mental and physical health. Analyses reported focused on work loss and cutbacks because of mental health or the combination of mental and physical health (cutbacks and days lost solely because of physical health were omitted from the analysis). Moreover, the analyses focused on "severe" cutbacks and lost work, operationalized as six or more days (during the past 30 days) cut back or lost.

Figure 13.3 illustrates that mental health and mental illness were also associated with impairments in work attendance and productivity. None of the flourishing adults had a severe work cutback or a severe loss of workdays in the past 30 days. Moreover, fewer than 1% of the moderately mentally healthy adults had a severe cutback of productivity or a severe loss of workdays. However, nearly as many adults with pure languishing as adults with pure depression had a severe loss of workdays. More than three times

as many adults with pure depression as with pure languishing had severe cutbacks in productivity. Finally, adults with the comorbid condition of languishing and depression were especially likely to have severe loss of workdays and severe cutbacks of productivity when compared with adults with pure depression and pure languishing.[9]

In short, flourishing and moderate mental health are associated with superior profiles of psychosocial functioning when compared with pure languishing and pure depression. The comorbid condition of languishing with a depressive episode was associated with the most psychosocial impairment relative to all other states of complete mental health. Pure languishing, or the absence of mental health, appears to be as burdensome to psychosocial functioning as an episode of pure depression. It is noteworthy that pure languishing is not subclinical depression. Adults who had "pure" languishing (i.e., no MDE) had an average of 0.1 (*SD* = 0.6) symptoms of depression, indicating that most of these individuals did not have even one symptom of depression.

CONCLUSION

Only recently has mental illness received the dubious but important distinction of being a disability as well as a disease of the brain. Based on data from 1990, the economic burden of major depression alone was estimated at $43.7 billion because of work absenteeism, diminished productivity, and treatment (Greenberg, Stiglin, Finkelstein, & Berndt, 1993). As a class, mental disorders were the third most costly condition in the United States in 1999, with combined direct and indirect costs of nearly $160 billion (Keyes & Lopez, 2002). Globally, depression in 1996 was ranked among the top five causes of disability and premature mortality, and depression is projected to become the second leading cause of disability and premature mortality by the year 2020 (Murray & Lopez, 1996). The treatment and prevention of mental illness, particularly major depression, are pressing issues facing many countries.

However, research reviewed in this chapter indicates that there are equally grave reasons for concern about the absence of mental health (i.e., languishing). Languishing corresponds with substantial psychosocial impairment. Languishing is associated with poor emotional health, with high limitations of daily living, and with a high likelihood of a severe number (i.e., six or more) of lost days of work (because of mental health). Although

[9]The association of mental health with psychosocial functioning and impairment was unchanged in multivariate models that include adjustment for a host of sociodemographic variables (i.e., sex, age, race, education, marital status, employment status).

it was not associated with severe work cutback, languishing was associated with more days of work cutback compared with moderately well adults. Pure depression was a burden that impaired psychosocial functioning; it was not, however, any more of a burden than pure languishing. Like languishing, a major depressive episode was associated with poor emotional health, high limitations of activities of daily living, and a high likelihood of severe work cutbacks and lost days of work.

Functioning was considerably worse when languishing was comorbid with a major depressive episode—in other words, individuals who were languishing and had depression in the past year. These individuals had the worst self-reported emotional health, the most limitations of activities of daily living, the most days of work lost, and the greatest cutback of productivity. In contrast, functioning was markedly improved among moderately well and flourishing adults. These adults reported the best emotional health, the fewest days of work loss, and the fewest days of work productivity cutbacks. Moreover, flourishing adults reported even fewer limitations of activities of daily living than adults who were moderately well. In short, research indicates that there are clear benefits to be obtained if we seek the objective of promoting complete mental health.

Pure languishing was more prevalent than a pure episode of major depression. Moreover, fewer than 2 in 10 adults between the ages of 25 and 74 were flourishing, and just more than one half had moderate mental health. When a major depressive episode was cross-classified with the mental health diagnosis, findings showed that languishing adults were at much greater risk for a depressive episode than adults who were flourishing or had moderate mental health. Because the MIDUS data are cross-sectional, however, causality between languishing and depression cannot be discerned and remains a topic for future investigation.

When extrapolated to the target population based on the 1995 U.S. Census Bureau's estimates (i.e., 154.5 million adults, aged 25 to 74), the prevalence estimates suggest that about 7.3 million adults were completely mentally ill with a depressive episode and languishing in life. Another 14.5 millions adults had pure depression, and 18.6 million had pure languishing. About 26.6 million adults were completely mentally healthy—in other words, flourishing in life. To put these estimates into perspective, the estimated number of individuals with pure languishing would literally replace the entire population of the state of New York, which had 18.9 million residents as of the most recent census.[10] Moreover, the number of mentally healthy, flourishing individuals would just replace the combined state popu-

[10]State populations are taken from the year 2000 U.S. Census Bureau's "geographic comparison tables" at http://factfinder.census.gov/servlet/BasicFactsServlet

lations of Texas (i.e., 20.9 million in 2000) and Missouri (i.e., 5.6 million in 2000).

What, in conclusion, should be the priorities of mental health policy, practice, and research in the 21st century? The modus operandi of the NIMH is supporting research related to identifying, treating, and preventing mental illnesses (see U.S. Department of Health and Human Services, 1995) to promote the mental health of the U.S. population. Proponents of the study of mental health, and the implications of this chapter, suggest that the current modus operandi of the NIMH is incomplete. Mental illness and mental health are correlated but separate continua. As such, prevention and treatment of mental illness will not necessarily result in more mentally healthy individuals. In fact, by focusing solely on mental illness, the NIMH cannot improve this nation's mental health. It can, however, reduce this nation's mental illness, which is a profoundly important step toward the objective of a mentally healthy population. A second and equally important step is to engage in genuine mental health promotion, which includes the objectives of reducing the amount of languishing adults and increasing the number of flourishing individuals in the population.

The study of mental health also raises new questions for the objectives and the nature of mental illness treatment and prevention. Treatment objectives for mental illness are symptom reduction and prevention of relapse (Gladis, Gosch, Dishuk, & Crits-Christoph, 1999; U.S. Department of Health and Human Services, 1999). However, findings summarized in this chapter suggest that mental health promotion is the ideal objective of treatment. Future research should also investigate whether and how languishing adults are at risk for depression. Most interventions to prevent mental illness are based on findings of the study of risk and protective factors for mental illness (i.e., "at risk" populations). Another source of prevention knowledge may be gleaned from the study of the life course and social contexts of mentally healthy youth and adults. Understanding the nature and etiology of the strengths and competencies of flourishing individuals may provide therapeutic insights for promoting strengths and competencies in mentally ill patients (see, e.g., Fava, 1999).

To achieve its goal of "improving this nation's health," the NIMH should marshal the political will and economic support in Congress to build a science of mental health in the same way it has, since 1946, built the science of mental illness. The promotion of flourishing, if nations are to thrive socially and economically, must also be an objective for the World Health Organization's public mental health efforts (see World Health Organization, 2001). The study and promotion of mental health can be a solution, not merely a slogan, for the future. In sum, it is time to truly pursue the study and promotion of mental health, and this is can be achieved with a more positive psychology as well as a more positive sociology.

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