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Corey L. M. Keyes (B. 1962) The Mental Health Continuum: From Languishing to Flourishing in Life (2002)

Think about how we describe someone who is mentally ill or who seems a bit “odd.” They are crazy, insane, mad as a hatter, psycho, mental, off his rocker, loony, abnormal, *non compos mentis*, nutty as a fruitcake, cuckoo, daft, unhinged, bananas, loco, whacko, out of her mind, or deranged. He has bats in his belfry. A screw loose. She’s lost her marbles. The list is endless.

Now think about how we describe someone who is mentally healthy. The list is a lot shorter. He or she might be described as mature or self-actualized or well-adjusted. There aren’t a lot of options, and they lack the pizzazz of the first list. Maybe that is why we devote much less attention to mental health than to mental illness. Maybe because so little attention has been devoted to mental health, we don’t have a rich vocabulary to talk about it. It is probably a little of both, and it is probably also a result of the general acceptance of the medical model of mental illness.

The medical model holds that when something is wrong with an individual the clinician’s role is to fix the problem, to cure the person, to eliminate the symptoms. Then the person is normal again. Normal means that there is nothing wrong. The fact that we call it mental “illness” and talk about “cure” and “symptoms” suggests that madness is analogous to if not identical with physical disorder. In applying the medical model to mental illness, a clinician’s goal is to remove a problematic behavior or set of ideas that is interfering with a person’s ability to live “normally.” When this is done, the person is okay, they are normal. Is this as good as it gets? Some psychologists have given attention to thinking about what it means to be something beyond “okay.”

Source: Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Behavior Research*, 43, 207–222.

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Gordon Allport (1937) devoted a chapter of his textbook on personality to the “mature personality.” In his view, the mature, or fully developed, individual has three qualities: a variety of interests and a willingness to set goals and to pursue them; insight and a sense of humor about the self; and a “unifying philosophy of life.” He urged psychologists to devote more attention to the study of positive human functioning:

It is especially in relation to the formation and development of human *personality* that we need to open doors. For it is precisely here that our ignorance and uncertainty are greatest. Our methods, however well suited to the study of sensory processes, animal research, and pathology, are not fully adequate; and interpretations arising from the exclusive use of these methods are stultifying. Some theories . . . are based largely upon the behavior of sick and anxious people or upon the antics of captive and desperate rats. Fewer theories have derived from the study of healthy beings, those who strive not so much to preserve life as to make it worth living. (1955, p.18)

In 1958 Marie Jahoda wrote *Current Concepts of Positive Mental Health*, a book usually considered to be the first on positive mental health. In the Introduction she writes:

Knowledge about deviations, illness, and malfunctioning far exceeds knowledge of healthy functioning. . . . [S]cience requires that the previous concentration on the study of inappropriate functioning be corrected by greater emphasis on appropriate functioning, if for no other reason than to test such assumptions as that health and illness are different only in degree.

Other members of the scientific community oppose . . . concern with mental health. In part such opposition is based on an unwillingness to work with a notion so vague. . . . In part it is rooted in the conviction that the science of behavior advances best by studying behavior, without reference to whether it is “good” or “bad.” Only in this manner . . . can science remain free from “contamination by values.” (p. 6)

In spite of the risk of getting values involved, Jahoda identifies six concepts associated with positive mental health: attitudes toward the self, development of self-actualization, integration of psychological functions, autonomy, accurate perception of reality, and environmental mastery.

Several other psychologists have contributed significantly to positive psychology. Abraham Maslow (e.g., 1954, 1968, 1970) wrote extensively about how and why psychology had gone wrong by studying only normative or negative behaviors and avoiding the issue of what the human experience could be:

If one is preoccupied with the insane, the neurotic, the psychopath, the criminal, the delinquent, the feeble-minded, one’s hopes for the human species become perforce more and more modest, more and more realistic, more and more scaled down. One expects less and less from people. From dreams of peace, affection, and brotherhood, we retreat. . . . (1954, p. 360)

Maslow’s theory was an influential attempt to right this wrong. His theory of motivation assumes that human needs and motivations are “organized into a hierarchy of relative prepotency”

(1954, p. 83; 1970, p.38). At each need level, a person must achieve reasonable satisfaction before moving on. The first needs that must be met are the physiological needs; for example, hunger and thirst. If these are not satisfied, the person does not move on to higher order needs: safety, belongingness and love, esteem, and finally the self-actualization need. The first four of the needs are considered deficiency needs; they motivate us to fulfill a deficit state. The need for self-actualization, however, is not based on deficiency. It is a positive desire to fulfill one's potential, and seeking self-actualization may increase, not decrease, tension. Those who are self-actualized share a number of qualities, such as accurate perception of reality, acceptance of self, autonomy, freshness of appreciation, mystic experiences, humor, and democratic character (Maslow, 1954, Chapter 12; Maslow, 1970, Chapter 11). In a later book, Maslow (1976) wrote more about the mystical experiences that self-actualized people have and referred to these as peak experiences, strong experiences of awe, selflessness, and wholeness.

Mihaly Csikszentmihalyi (1990, 1993, 1997) introduced the term "flow," a concept similar to Maslow's concept of peak experience. Csikszentmihalyi had begun his research on creativity and first introduced "flow" to refer to the total involvement that artists have when painting. He soon realized that this experience is not confined to artists but occurs in many kinds of people and in many kinds of settings. He extended the notion of flow to activities in which a person is totally absorbed. As did Maslow, Csikszentmihalyi believes that people who experience flow frequently are much more likely to be psychologically healthy and that social pressures often constrict us and limit our psychological health. We are taught to follow the rules. As a result, many of us are conventional, rather dull, and not terribly happy. We need to be more independent of social constraints and to find goals and activities that reward and satisfy us. Csikszentmihalyi writes about the nature of the flow experience itself, the discipline necessary to experience flow, the child rearing practices that are most likely to facilitate the experience, and the personality characteristics associated with individuals who experience flow most frequently.

Interest in positive psychology seems to have increased significantly in the 1990s, and there are now new concepts and much more research on mental health. One of the difficulties faced by those studying positive psychology is, as Marie Jahoda warned in 1958, defining "mental health." Another possible problem is that of avoiding "contamination by values" (Jahoda, 1958, p. 6). But, these same issues of vagueness and values exist when we try to define "abnormality."

Corey Keyes is one of the most active contributors to positive psychology. Keyes describes the mentally healthy as "flourishing," and he has done a substantial amount of research to identify the characteristics associated with flourishing. Keyes also introduced a new concept to positive psychology—languishing. In the present reading, about 17.2% of adults are flourishing. Another 56.6% are moderately mentally healthy (they're "okay"), 12.1% are languishing, and 14.1% are depressed. Those who are languishing are not mentally ill, but they show few signs of mental health. Because his conceptual approach goes far beyond simply looking at the super-healthy and because his ideas are grounded in empirical work, Keyes has created a framework for thinking about mental health—its presence and its absence—that makes it possible for him to ask a range of new questions.

Keyes's article provides new ways to think about mental health. He argues skillfully for the importance of facilitating flourishing and for paying attention to the problems associated with languishing, and he provides a conceptual framework that will allow us to learn more about what flourishing is, who the people are who are languishing, and what the consequences are of being at different points along the mental health continuum.

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etiology: the study of causes

There are grave reasons for concern about the prevalence and etiology of mental illness. Unipolar depression, for example, strikes many individuals annually and recurrently throughout life (Angst, 1988; Gonzales, Lewinsohn, and Clarke, 1985). Upwards of one-half of adults may experience a serious mental illness in their lifetime; between 10 percent and 14 percent of adults experience an episode of major depression annually (Cross-National Collaborative Group, 1992; Kessler et al., 1994; Robins and Regier, 1991; U.S. Department of Health and Human Services, 1999). As a persistent and substantial deviation from normal functioning, mental illness impairs the execution of social roles (e.g., employee) and it is associated with emotional suffering (Keyes, 2001; Spitzer and Wilson, 1975). Depression costs billions each year due to work absenteeism, diminished productivity, healthcare costs (Greenberg et al., 1993; Keyes and Lopez, 2002; Murray and Lopez, 1996; Mrazek and Haggerty, 1994), and it accounts for at least one-third of completed suicides (Rebllon, Brown, and Keyes, 2001; U.S. Department of Health and Human Services, 1998).

Yet about one-half of the adult population should remain free of serious mental illnesses over its lifespan, and as much as 90 percent should remain free of major depression annually.

In this paper, when Keyes says “mental illness” he is referring exclusively to depression.

Are adults who remain free of mental illness annually and over a lifetime mentally healthy and productive? This is a pivotal question for proponents of the study of mental health (Keyes and Shapiro, 2004), and it is the guiding question to this study.

Mental health is, according to the Surgeon General (U.S. Department of Health and Human Services, 1999), “. . . a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with people, and the ability to adapt to change and to cope with adversity” (p. 4). Social scientists have lobbied over 40 years for a definition of mental health as more than the absence of mental illness (Jahoda, 1958). M. Brewster Smith (1959) lamented that “positive” mental health is a “slogan” and a “rallying call” rather than the empirical concept and variable it deserves to be. Despite the Surgeon General’s definition 41 years later, mental health remains the antonym of mental illness and a catchword of inert good intentions.

syndrome: a set of symptoms that occur together. In traditional clinical language, a syndrome is a particular disorder. Here Keyes is forcing us out of this traditional usage.

This paper introduces and applies an operationalization of mental health as a syndrome of symptoms of positive feelings and positive functioning in life. It summarizes the scales and dimensions of subjective well-being, which are symptoms of mental health. Whereas the presence of mental health is described as flourishing, the absence of mental health is characterized as languishing in life.

Subsequently, this study addresses four research questions. First, what is the prevalence of flourishing, languishing, and moderate mental health in the United States?

Second, what is the burden of languishing relative to major depression episode and to flourishing in life? Third, is mental health (flourishing) associated with better psychosocial functioning relative to major depression and languishing in life? Fourth, is mental health, like most mental illnesses, unequally distributed in the population; who, in other words, is mentally healthy?

More on these questions can be found in Keyes (2007).

MENTAL HEALTH AND ITS SYMPTOMS

Like mental illness, mental health is defined here as an emergent condition based on the concept of a syndrome. A state of health, like illness, is indicated when a set of symptoms at a specific level are present for a specified duration and this constellation of symptoms coincides with distinctive cognitive and social functioning (cf. Keyes, 2001; Mechanic, 1999). Mental health may be operationalized as a syndrome of symptoms of an individual's subjective well-being. During the last 40 years, social scientists have conceptualized, measured, and studied the measurement structure of mental health through the investigation of subjective well-being (e.g., Headey, Kelley, and Wearing, 1993; Keyes, Shmotkin, and Ryff, 2002). Subjective well-being is individuals' perceptions and evaluations of their own lives in terms of their affective states and their psychological and social functioning (Keyes and Waterman, 2003).

Emotional well-being is a cluster of symptoms reflecting the presence or absence of positive feelings about life. Symptoms of emotional well-being are ascertained from individuals' responses to structured scales measuring the presence of positive affect (e.g., individuals is in good spirits), the absence of negative affect (e.g., individual is not hopeless), and perceived satisfaction 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 and 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 and Withey, 1976; Bryant and Veroff, 1982; Diener, 1984; Diener, Sandvik, and Pavot, 1991; Diener et al., 1999).

Like mental illness (viz. depression), mental health is more than the presence and absence of emotional states. In addition, subjective well-being includes measures of the presence and absence of positive functioning in life. Since Ryff's (1989) operationalization of clinical and personality theorists' conceptions of positive functioning (Jahoda, 1958), the field has moved toward a broader set of measures of well-being. Positive functioning consists of six dimensions of psychological well-being: self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery, and autonomy (see Keyes and Ryff's 1999 review). That is, individuals are functioning well when they like most parts of themselves, have warm and trusting relationships, see themselves developing into better people, have a direction in life, are able to shape their environments to satisfy their needs, and have a degree of self-determination. The psychological well-being scales are well-validated and reliable (Ryff, 1989), and the

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validity: the extent to which a test measures what it is intended to measure

reliability: consistency measurement over time or within a test

six-factor structure has been confirmed in a large and representative sample of U.S. adults (Ryff and Keyes, 1995).

However, there is more to functioning well in life than psychological well-being. Elsewhere (Keyes, 1998) I have argued that positive functioning includes social challenges and tasks, and

I proposed five dimensions of social well-being. Whereas psychological well-being represents more private and personal criteria for evaluation of one's 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 functioning well when they see

construct validity: the extent to which the results of a test agree with other measures of the same quality or predict particular outcomes in expected ways

society as meaningful and understandable, when they see society as possessing potential for growth, when they feel they belong to and are accepted by their communities, when they accept most parts of society, and when they see themselves contributing to society. The social well-being scales have shown good construct validity

and internal consistency, and the five-factor structure has been confirmed in two studies based on data from a nationally representative sample of adults (Keyes, 1998).

It is probably less evident that the dimensions of social well-being, compared with emotional and psychological well-being, are indicative of an individual's mental health. However, the Surgeon General's definition of mental health included particular reference to criteria such as "productive activities," "fulfilling relationships," and "the ability to adapt to change," all of which imply the quality of an individual's complete engagement in society and life. Measures of emotional well-being often identify an individual's satisfaction or positive affect with "life overall," but rarely with facets of their social lives. The dimensions of psychological well-being are intra-personal reflections of an individual's adjustment to and outlook on their life. Only one of the six

factor analysis: a statistical procedure in which correlations among a large number of variables are used to identify higher-level groups (factors) of variables

scales of psychological well-being—positive relations with others—reflects the ability to build and maintain intimate and trusting interpersonal relationships. I have argued elsewhere and have shown empirically (Keyes, 1998) that an individual's adjustment to life includes the aforementioned facets of social well-being. That is, factor analyses showed

that the mental health measures formed three correlated but distinct factors: emotional, psychological, and social well-being.

Last, some dimensions of social well-being (viz. social integration) are identical with theoretical explanations of interpersonal and societal level causes of mental health (e.g., social support and social networks). We have argued elsewhere (Keyes and Shapiro, 2004) that constructs

such as social integration exist at multiple levels of analysis (i.e., societal, interpersonal, and individual). However, I concur with Larson (1996), who said that “The key to deciding whether a measure of social well-being is part of an individual’s health is whether the measure reflects *internal* responses to stimuli—feelings, thoughts and behaviors reflecting satisfaction or lack of satisfaction with the social environment” (p. 186). From this perspective, the measures of social well-being, like the measures of psychological and emotional well-being, should be viewed as indicators of an individual’s mental health status.

TOWARD A DIAGNOSIS OF MENTAL HEALTH

Empirically, mental health and mental illness are not opposite ends of a single measurement continuum. Measures of symptoms of mental illness (viz. depression) correlate negatively and modestly with measures of subjective well-being. In two separate studies reviewed by Ryff and Keyes (1995), the measures of psychological well-being 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 et al., 1992).

Confirmatory factor analyses of the sub-scales of the CESD and the scales of psychological well-being scales in a sample of U.S. adults supported the two-factor theory (Keyes, Ryff, and Lee, 2001). That is, the best-fitting model was one where the CESD subscales were indicators of . . . the presence and absence of mental illness (see also Headey et al., 1993). The psychological well-being scales were indicators of . . . the presence and absence of mental health. In short, mental health is not merely the absence of mental illness; it is not simply the presence of high levels of subjective well-being. Mental health is best viewed as a complete state consisting of the presence and the absence of mental illness and mental health symptoms.

The mental health continuum consists of complete and incomplete mental health. Adults with complete mental health are *flourishing* in life with high levels of well-being. To be flourishing, then, is to be filled with positive emotion and to be functioning well psychologically and socially. Adults with incomplete mental health are *languishing* in life with low well-being. Thus, languishing may be conceived of as emptiness and stagnation, constituting a life of quiet despair that parallels accounts of individuals who describe themselves and life as “hollow,” “empty,” “a shell,” and “a void” (see Cushman, 1990; Keyes, 2003; Levy, 1984; Singer, 1977).

Conceptually and empirically, measures of subjective well-being fall into two clusters of symptoms: emotional and functional well-being. The measures of emotional well-being comprise a cluster that reflects emotional vitality. In turn, the measures of psychological well-being and social well-being reflect a multifaceted cluster of symptoms of positive functioning. These two clusters of mental health symptoms mirror the symptom clusters used in the DSM-III-R

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DSM: Diagnostic and Statistical Manual, a manual published by the American Psychiatric Association that classifies mental disorders

(American Psychiatric Association, 1987) to diagnose major depression episode. Major depression consists of symptoms of depressed mood or anhedonia (e.g., loss of pleasure derived from activities) and a multifaceted cluster of symptoms (i.e., vegetative and hyperactive) of malfunctioning (e.g., insomnia or hypersomnia). Of the nine symptoms of major depression, a diagnosis of depression is warranted when a respondent reports five or more symptoms, with at least one symptom coming from the affective cluster.

Five or more of the following symptoms most days during a two week period are sufficient for the diagnosis of a major depressive episode (DSM-IV-TR, 2000):

1. Depressed mood most of the day
2. Markedly diminished interest or pleasure in almost all activities
3. Significant weight gain or loss, or decrease or increase in appetite
4. Insomnia (trouble sleeping) or hypersomnia (excessive sleeping)
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive guilt
8. Decreased ability to think or concentrate, or indecisiveness
9. Thoughts of death or suicide, a suicide attempt, or creating a specific plan for committing suicide

The first two are affective (emotional) indicators of depression.

The DSM approach to the diagnosis of major depression is employed as a theoretical guide for the diagnosis of mental health, whose symptom clusters mirror theoretically and empirically the symptom clusters for depression. That is, mental health is best operationalized as [a] syndrome that combines symptoms of emotional well-being with symptoms of psychological and social well-being. In the present study, respondents completed a structured scale of positive affect and a question about life satisfaction (i.e., emotional well-being). Respondents also completed the six scales of psychological well-being and the five scales of social well-being. Altogether, this study included two symptom scales of emotional vitality, and 11 symptom scales of positive functioning (i.e., six psychological and five social).

The diagnostic scheme for mental health parallels the scheme employed to diagnose major depression disorder wherein individuals must exhibit just over half of the total symptoms (i.e., at least five of nine). To be *languishing* in life, individuals must exhibit a low level (low = lower tertile) on one of the two measures of emotional well-being, and low levels on six of the 11 scales of positive functioning. To be *flourishing* in life,

lower tertile: lower third of the distribution

individuals must exhibit a high level (high = upper tertile) on one of the two measures 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. . . .

METHODS

Sample

Data are from the MacArthur Foundation's Midlife in the United States survey. This survey was a random-digit-dialing sample of non-institutionalized English-speaking adults age 25 to 74 living in the 48 contiguous states, whose household included at least one telephone. In the first stage of the multistage sampling design, investigators selected households with equal probability via telephone numbers. At the second stage, they used disproportionate stratified sampling to select respondents. The sample was stratified by age and sex, and males between ages 65 and 74 were over-sampled.

Field procedures were initiated in January of 1995 and lasted 13 months. Respondents were contacted and interviewed by trained personnel, and those who agreed to participate in the entire study took part in a computer-assisted telephone interview lasting 30 minutes, on average. Respondents then were mailed two questionnaire booklets requiring 1.5 hours, on average, to complete. Respondents were offered \$20, a commemorative pen, periodic reports of study findings, and a copy of a monograph on the study.

The sample consists of 3,032 adults. With a 70 percent response rate for the telephone phase and an 87 percent response rate for the self-administered questionnaire phase, the combined response is 61 percent ($.70 \times .87 = .61$). Descriptive analyses are based on the weighted sample to correct for unequal probabilities of household and within household respondent selection. The sample weight post-stratifies the sample to match the proportions of adults according to age, gender, education, marital status, race, residence (i.e., metropolitan and non-metropolitan), and region (Northeast, Midwest, South, and West) based on the October 1995 Current Population Survey.

Measures

The measures that Keyes used in this study were

Mental illness, measured by the CIDI-SF (Composite International Diagnostic Interview Short Form) scales (Kessler et al., 1998)

Mental health, measured by a total of 13 scales:

Two scales measured emotional well-being:

Positive Affect Scale

Life Satisfaction Scale

(Continued)

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(Continued)

Six scales measured psychological well-being:

- Self-acceptance Scale
- Positive Relations with Others Scale
- Personal Growth Scale
- Purpose in Life Scale
- Environmental Mastery Scale
- Autonomy Scale

Five scales measured social well-being:

- Social Acceptance Scale
- Social Actualization Scale
- Social Contribution Scale
- Social Coherence Scale
- Social Integration Scale

Psychological functioning and impairment, measured by three scales:

- Rating of their own emotional, mental health
- Rating of the degree to which their health limited them in the activities of daily life
- Estimate of the number of workdays they had lost or shortened

Sociodemographic variables included here were age, sex, race, marital status, and education.

RESULTS

Prevalence

From the frequencies reported in Table 1, the percentages in this paragraph should be as follows: Of adults who did not have depression 20.0% were flourishing, 14.1% were languishing, and 65.9% were moderately mentally healthy. Of adults who did have depression 6.3% were flourishing, 60.4% had moderate mental health, and 33.3% were languishing.

Table 1 presents the prevalence estimates of major depression episode and mental health status, as well as the cross-classification of mental health status with major depression. Most adults, 85.9 percent, did not have a depressive episode. Only 17.2 percent of adults who did not have depression were flourishing in life, 12.1 percent were languishing in life, and just over one-half were moderately mentally healthy. Of the 14.1 percent of adults who had a depressive episode during the past year, only

0.9 percent were flourishing, 8.5 percent had moderate mental health, and 4.7 percent were also languishing.

Exactly 28 percent of languishing adults had major depression, while 13.1 percent of adults with moderate mental health, and 4.9 percent of flourishing adults, had a major depressive episode during the past year. Thus, compared with flourishing adults, moderately well adults were about 2.1 times more likely to have had major depression during the past year, while languishing adults were 5.7 times more likely. These findings, though cross-sectional, suggest that the absence of mental health (languishing) may be a risk factor for episodes of major depression.

TABLE 1 The Prevalence of Mental Health and Major Depression among Adults between the Ages of 25 and 74 in the 1995 Midlife in the United States Study

| | | <i>Mental Health Status</i> | | | |
|----------------------|-------------------|-----------------------------|------------------------------------|--------------------|----------------|
| | | <i>Languishing</i> | <i>Moderately Mentally Healthy</i> | <i>Flourishing</i> | <i>Total</i> |
| <i>Major Episode</i> | <i>Depressive</i> | <i>N</i> % | <i>N</i> % | <i>N</i> % | <i>N</i> % |
| NO | | 368 12.1 | | 520 17.2 | 2,603 85.9 |
| | | Pure Languishing | | Flourishing | |
| YES | | 143 4.7 | 259 8.5 | 27 0.9 | 429 14.1 |
| | | Depressed and Languishing | Pure Depression | Pure Depression | |
| TOTAL | | 511 16.8 % | 1,974 65.1 | 547 18.1 % | 3,032 100 % |

Is pure languishing confounded with subthreshold depression? Studies have consistently shown that depressive symptoms that do not meet the criteria for major depression are associated with physical disease and functional impairments at levels sometimes comparable to that of major depression (see Pincus, Davis, and McQueen, 1999). Thus, it would be unclear whether any association of languishing with functional impairment is due to the absence of mental health or the presence of some symptoms of depression. However, the mean number of symptoms of depression (range = 0–9) among adults with pure languishing (i.e., not depressed) was .13 (SD = .58). Thus, nearly all adults with pure languishing had no symptom of depression and therefore did not fit the criteria for any form of subthreshold /Author: please verify inconsistent hyphenation of subthreshold depression (e.g., minor depression or dysthymia).

dysthymia: a chronic depressive mood state

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Psychosocial Functioning and Impairment

Table 2 presents the bivariate association of the prevalence of indicators of levels of impairment with the combined diagnosis of major depression episode and mental health. About 18 percent of languishing adults, and 22 percent of adults with depression, said their emotional health was poor or fair; over twice as many, 55 percent, of languishing adults who had depression during the past year said their emotional health was poor or fair. Only 6 percent of moderately well and 1 percent of flourishing adults said their emotional health was poor or fair. In contrast, about 61 percent of moderately well and 81 percent of flourishing adults said their emotional health was very good or excellent. About 34 percent of languishing adults, 35 percent of adults with pure depression, and only 15 percent of languishing adults with major depression said their emotional health was very good or excellent.

TABLE 2 Prevalence of Psychosocial Impairment by Mental Illness and Mental Health Status

| Impairment Indicator | Mental Illness and Mental Health Status | | | | | χ^2 |
|--|---|--------------------|---------------------|-----------------------------------|-------------|---------------------|
| | Languishing and Depression | Pure Depression | Pure Languishing | Moderately Mentally Healthy | Flourishing | |
| Emotional Health | | | | | | 660.1 *** df = 8 |
| Poor or Fair | 55.2 | 22.2 | 17.7 | 5.7 | 0.6 | |
| Good | 29.4 | 43.3 | 48.2 | 33.9 | 18.1 | |
| Very Good or Excellent | 15.4 | 34.5 | 34.1 | 60.5 | 81.3 | |
| One or More Severe ^a Limitation of Daily Activities of Living | 69.4 | 54.7 | 64.0 | 54.7 | 42.0 | 59.1 *** df = 4 |
| Six or More Work Days Lost ^b | 11.9 | 2.5 | 2.2 | 0.5 | 0 | 144.1 *** df = 4 |
| Six or More Work Days Cutback ^c | 16.8 | 7.0 | 1.6 | 0.4 | 0 | 243.0 *** df = 4 |

Note: * $p < .05$ ** $p < .01$ *** $p < .001$ (two-tailed)

a. Defined as any activity in which respondent perceived "a lot" of limitation.

b. Number days of past 30 in which respondent was completely unable to work due to reasons of mental health or to combination of mental and physical health.

c. Number days of past 30 in which respondent had to reduce or cutback on amount of work completed due to reasons of mental health or to combination of mental and physical health.

Next, the analysis focused on severe activity limitation, operationalized as the report of “a lot” of limitation in one or more activities of daily living. About 64 percent of languishers, 55 percent of depressed only adults, and 69 percent of the languishing adults who also had major depression, reported a severe activity limitation. Moreover, 55 percent of moderately mentally healthy adults, compared with 42 percent of flourishing adults, reported a severe limitation of daily living in at least one activity. Last, the analysis focused on severe loss of workdays and severe cutbacks, where severe was operationalized as a loss or cutback of six or more days during the past 30 days. About 2 percent of languishing, 2.5 percent of depressed, and 12 percent of the languishing adults with an episode of major depression had a severe level of workdays lost due to mental health. Only .5 percent of moderately mentally healthy, and none of the flourishing adults, had a severe level of workdays lost due to mental health. In terms of work cutback, 1.6 percent of languishing, 7 percent of depressed only, and 17 percent of languishing adults with an episode of major depression had a severe level of work cutback due to mental health. Only .4 percent of the moderately mentally healthy and none of the flourishing adults had a severe level of workdays cut back due to mental health.

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Who is mentally healthy? Table 3 presents the descriptive epidemiology of the mental health diagnosis by gender, age, education, and marital status. Consistent with prior research, this study finds a higher prevalence of poor mental health

Epidemiology is the study of the prevalence and distribution of illness (and health).

among females, younger adults, less educated individuals, and unmarried adults. Pure depression is more prevalent among females, among adults between the ages of 25 to 54, and among separated and divorced individuals. Pure depression is about equally prevalent across the educational categories. The most dysfunctional category of languishing with an episode of depression is more prevalent among females, among adults between the ages of 25 and 54, among individuals with 11 or fewer years of education, and among divorced individuals. Pure languishing is more prevalent among younger adults between the ages of 25 and 64, among adults with a high school degree (or equivalent) or less, and among adults who are separated from their spouse; pure languishing is about equally prevalent for males and females. Mental health, or flourishing in particular, is more prevalent among males, older adults between the ages of 45 and 74, individuals with 16 or more years of education, and among married adults. The findings are therefore consistent with and extend past research. . . .

DISCUSSION

Many individuals remain free of mental illness each year and over their lifetimes. However, is the absence of mental illness reflective of genuine mental health? The Midlife in the United States study provides a rare opportunity to investigate the costs and benefits associated with the absence (i.e., languishing) and the presence (i.e., flourishing) of mental health as well as

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mental illnesses such as major depression. The results of this paper suggest there are two grave reasons to be as concerned about pure languishing in life (i.e., the absence of mental health and mental illness) as the presence [of] major depression. First, pure languishing is associated with substantial psychosocial impairment at levels comparable to an episode of pure depression. Second, pure languishing is as prevalent as pure episodes of major depression in this study.

Languishing is associated with poor emotional health, with high limitations of daily living, and with a high likelihood of a severe number (i.e., 6 or more) of lost days of work . . . that respondents attribute to their mental health. . . . Pure depression, too, was a burden. A major depressive episode was associated with poor emotional health, high limitations of activities of daily living, and a high likelihood of severe work cutback. . . .

Functioning is considerably worse when languishing and major depressive episode are comorbid during the past year. Languishing adults who had a major depressive episode in the

comorbid: a disorder that appears in conjunction with another disorder

past year reported the worst emotional health, the most limitation of activities of daily living, the most days of work lost and cut back, and the highest probability of having severe levels of workdays lost and workdays cut back by half. In contrast, functioning is markedly improved

among mentally healthy adults. That is, moderately mentally healthy and flourishing adults reported the best emotional health, the fewest days of work loss, and the fewest days of work cutbacks. Moreover, flourishing adults reported even fewer limitations of activities of daily living than adults who were moderately mentally healthy.

Languishing was as prevalent as having an episode of major depression. Nearly 5 percent of the sample had the most debilitating condition of languishing combined with an episode

45 million: according to Table 1, 26.2% of the sample were languishing, depressed, or both, and so the population prevalence would be about 40.5 million. From the same data, about 28 million would be flourishing.

of major depression. Less than one-quarter of adults were flourishing; one-half of adults had a moderate level of mental health. When extrapolated to the target population,¹ the prevalence estimates suggest that a combined total of 45 million adults were either languishing, depressed, or both (which constituted 29 percent of the sample). By comparison, about 32 million adults were mentally healthy based on the prevalence of flourishing in life. The bulk of the population is neither mentally ill nor mentally healthy. . . .

The second limitation, not included here, is a technical issue having to do with the nature of the scales used in this study.

There are two important study limitations that suggest directions for future research. First, the

¹ Data from the Census Bureau suggested that the target population of adults between the ages of 25 and 74 in 1995 was approximately 154 million.

data are cross-sectional. The ability to collect data from the Midlife in the United States survey respondents in successive waves would permit investigation of whether languishing causes work impairments and physical disability or whether work cutbacks and the onset of physical disability cause languishing. That said, cross-sectional studies of the burden of depression have been followed up with longitudinal studies showing that depression caused physical disability and diminished work productivity (Broadhead et al., 1990; Bruce et al. 1994). Languishing, too, may precede many forms of psychosocial impairment. Moreover, flourishing in life, and perhaps moderate mental health, could be a source of resilience, acting as a stress buffer against stressful life events and life transitions.

...

Despite this study's limitation, its findings have implications for the conception of mental health and the treatment and prevention of mental illness. The National Institute of Mental Health (NIMH) periodically convenes scholars to identify research priorities. The first sentence in the 1995 report (U.S. Department of Health and Human Services, 1995) states that the mission of the NIMH is "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*" (p. 1) (emphasis added). Based on the present study, the question is whether the NIMH can "get there (i.e., to mental health) from here (i.e., mental disorders)."

Proponents of the study of mental health, and the implications of this study, would suggest that the mission of the NIMH is incomplete. Mental illness and mental health are highly correlated but belong to separate continua, and therefore the prevention and treatment of mental illnesses will not necessarily result in more mentally healthy individuals. Moreover, there appears to be a Pandora's box of economic and social burdens associated with the absence (i.e., languishing) of mental health, which is completely ignored by current programs in the NIMH and elsewhere (e.g., World Health Organization). The promotion of this nation's mental health will require programmatic infrastructure and funding for a wide range of research related to the etiology, diagnosis, treatment, prevention, and promotion of the absence and presence of mental health.

Moreover, treatment objectives for mental illness are symptom reduction and prevention of relapse (Gladis et al., 1999; U.S. Department of Health and Human Services, 1999). However, findings from this study suggest mental health promotion should be the preeminent treatment objective. Moreover, interventions to prevent mental illness are based on findings of the study of risk and protective factors for mental illness. Future research should also investigate whether and how languishing adults are at risk for depression. 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). It is time, in short, to retire the slogan of mental health and to invigorate the study and promotion of mental health.

616 PART VI NORMAL & ABNORMALS**TABLE 3** The Prevalence of Mental Health and Illness by Select Sociodemographic Characteristics (Sample Weighted).

| <i>Sociodemographics</i> | <i>Mental Illness and Mental Health Status</i> | | | | | χ^2 |
|--------------------------|--|----------------------------|-----------------------------|--|--------------------|---------------------|
| | <i>Languishing and Depression</i> | <i>Pure Depression</i> | <i>Pure Languishing</i> | <i>Moderately Mentally Healthy</i> | <i>Flourishing</i> | |
| | <i>N</i> % | <i>N</i> % | <i>N</i> % | <i>N</i> % | <i>N</i> % | |
| Gender | | | | | | |
| Males | 40 3.0 | 93 7.1 | 158 12.0 | 763 57.9 | 264 20.0 | 40.4*** df = 4 |
| Females | 104 6.1 | 193 11.3 | 210 12.2 | 952 55.5 | 256 14.9 | |
| Age | | | | | | |
| 25 to 34 | 44 5.6 | 93 11.9 | 85 10.8 | 44 57.0 | 115 14.7 | 72.2*** df = 16 |
| 35 to 44 | 53 6.4 | 92 11.0 | 129 15.5 | 437 52.4 | 123 14.7 | |
| 45 to 54 | 26 4.5 | 52 9.1 | 66 11.5 | 307 53.5 | 123 21.4 | |
| 55 to 64 | 11 2.4 | 29 6.3 | 49 10.7 | 273 59.7 | 95 20.8 | |
| 65 to 74 | 8 2.3 | 19 5.4 | 33 9.3 | 237 66.8 | 58 16.3 | |
| Education | | | | | | |
| 0 to 11 years | 38 9.5 | 36 9.0 | 53 13.3 | 227 56.9 | 45 11.3 | 122.4*** df = 16 |
| 12 years or GED | 51 4.4 | 100 8.6 | 178 15.3 | 659 56.8 | 173 14.9 | |
| 13 to 15 years | 39 5.0 | 82 10.6 | 989 12.7 | 440 56.9 | 114 188 | |
| 16 years or more | 15 2.2 | 67 9.6 | 37 5.3 | 390 56.0 | 188 | |
| Marital Status | | | | | | |
| Married | 74 3.6 | 167 8.1 | 234 11.3 | 1,187 57.5 | 404 19.6 | 84.1*** df = 16 |
| Separated | 5 6.0 | 15 18.1 | 17 20.5 | 36 43.4 | 10 12.0 | |
| Divorced | 38 9.6 | 53 13.4 | 59 14.9 | 204 51.6 | 41 10.4 | |
| Widowed | 5 3.6 | 14 10.0 | 12 8.6 | 88 62.9 | 21 15.0 | |
| Never Married | 21 6.0 | 37 10.6 | 46 13.1 | 201 57.4 | 45 12.9 | |

Note: * $p < .05$ ** $p < .01$ *** $p < .001$ (two-tailed)

FOR DISCUSSION

1. Keyes reports that about 1% of the population is flourishing and severely depressed (or, to put it another way, about 5% of those who are flourishing are severely depressed). What can we make of this?
2. Keyes reports that people who are more mentally healthy miss fewer days of work, cut back on work on fewer days, and have fewer limitations in their daily lives. What are the possible reasons for these relationships?
3. As Keyes points out, the data from this study indicate that languishing may be as debilitating as major depression (although the combination of the two is considerably more debilitating than either alone). Because about 12% of the population is languishing but not depressed (and presumably not in treatment) how might we, as a society, reach out to languishers?
4. How, as a society, could we help people to flourish?
5. The Midlife in the U. S. (MIDUS; Brim, Ryff, & Kessler, 2004) study has information about a wide range of demographic characteristics, attitudes, feelings, mental health, and experience. If you had access to the data, what additional questions would you like to ask?

