

# A Calculation of National Wellness

| Stephan A. Schwartz |

Socrates said of medicine, “This ‘medicine’ this philter, which acts as both remedy and poison . . . This charm, this spellbinding virtue, this power of fascination, can be—alternately or simultaneously—beneficent or maleficent.”<sup>1</sup>

The clear implication is that it is not the medication but the choice of how and when to use it, and the social context that leads to its use, that should be considered. But it is not the pharmacology per se upon which I wish to focus. Instead, consider: the usage of antidepressant drugs gives us a read out, as clear as any instrument measuring a patient, and it tells us something important about our national wellness.

PsychCentral, the Internet’s largest and oldest fact-based mental health network, defines major depression as, “the kind of depression that will most likely benefit from treatment with medications, (that) is more than just ‘the blues.’ It is a condition that lasts 2 weeks or longer, and interferes with a person’s ability to carry on daily tasks and enjoy activities that previously brought pleasure. Depression is associated with abnormal functioning of the brain. An interaction between genetic tendency and life history appears to determine a person’s chance of becoming depressed. Episodes of depression may be triggered by stress, difficult life events, side effects of medications, or medication/substance withdrawal, or even viral infections that can affect the brain.”<sup>2</sup> They should have

added environmental factors, in my opinion, but the basics of this definition are what guides physicians.

That is the condition statement of an individual. What does that look like at the social level? According to the Centers for Disease Control, a research team headed by psychologist Laura Pratt, as part of the National Health and Nutrition Examination Surveys 2005-2008, reports that:

- Eleven percent of Americans aged 12 years and older take antidepressant medication.
- Women are more likely to take antidepressants than are men, and non-Hispanic white persons are more likely to take antidepressants than are non-Hispanic black and Mexican-American persons.
- Approximately one-third of persons with severe depressive symptoms take antidepressant medication.
- More than 60% of Americans taking antidepressant medication have taken it for 2 years or longer, with 14% having taken the medication for 10 years or more.
- Less than one-third of Americans taking one antidepressant medication and less than one-half of those taking multiple antidepressants have seen a mental health professional in the past year.<sup>3</sup>

To place that in even greater context: Antidepressant drug usage during the past decade has gone from 5.84% of the population to the new 11%.<sup>4</sup> Approximately one-quarter of American women are taking some kind of medication to treat a mental health condition, mostly depression. According to a study performed by Medco Health Solutions, “women of all ages take more mental health medications than

males, with antidepressants being the most commonly used.”

“Anxiety treatments are used by women at almost twice the rate of men, and the largest age group using these drugs are women between 45 and 65 years of age.”

The number of women on attention deficit-hyperactivity disorder (ADHD) drugs was 2.5 times greater than in 2001. Women between the ages of 20 to 44 years used ADHD drugs 264% times more often than they did 10 years ago.<sup>5</sup>

They also report that approximately 14% “of Americans taking antidepressants medication have done so for 10 years or longer.”<sup>3</sup>

Between 1996 and 2005, antidepressant medication usage has increased by 75%.<sup>6</sup>

About 16%, almost 50 million of us, are seriously not happy, and feeling unhappy is not just an emotional issue. Chronic unhappiness has wide range of other health consequences.

As if that were not bad enough, Mark Olfson, MD, MPH, and Steven Marcus, PhD, whose 2009 study on this was published in *Archives of General Psychiatry*, make another point about the pharmacological-only approach; one confirming the CDC - Pratt study. Increasingly patients have less and less oversight even as they become more and more drug dependent. “Not only are more U.S. residents being treated with antidepressants,” they say, “they are receiving more antidepressant prescriptions,” with less and less expert supervision.<sup>6</sup> In addition, a growing number of these prescriptions are written not by psychiatrists but primary care physicians. So the result is that as chronic unhappiness is increasing exponentially in our society the case management of these patients is largely being handled not with drugs expertly selected after the close human contact offered by specialized psy-

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chotherapy, but in 15 minute visits with an overworked primary care physician, culminating in a prescription for powerful pills known to have a wide range of side-effects.

Pause for a moment and consider what these numbers are challenging us to realize: nearly 50 million Americans have a quality of life that has left them so depressed that they take regular medications, most of which decrease libido and have a myriad of other side effects. Just listen any day to those television commercials in which to a visual sequence a voice over lists a series of horrible things that can happen to you, “including death” if you happen to be one of the unlucky minority that experiences side effects. Is there anything in this scenario that seems likely to deal with the complex root causes that lead to chronic unhappiness? I don’t think so, and the results seem to support this conclusion.

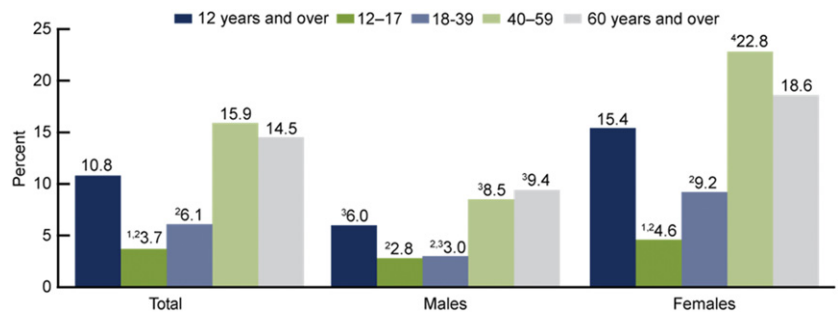
It is easy to see why this is incredibly profitable for the illness profit system, and the vast pharmaceutical industry that controls it. But one sees little here to suggest an increase in happiness for either the patient or the society of which they are a part. Is it really in the national interest to have millions of adults and children going around in a drugged state every day of their lives?

Consider Figure 1. When you look at the chart, pay particular attention to the number of 12- to 17-year-old patients taking these drugs.

How can one not conclude that our Illness Profit model of healthcare is a failure, as is our larger social safety network? This Olfson and Marcus study is not a revelation in that regard, rather a confirmation, another social outcome failure, joining infant and maternal mortality, life expectancy, and on and on, all wrapped in a seemingly impenetrable network of excessive costs. This calibration of our national wellness tells us we are deeply unhappy, and that our approach to handling this is a failure.

It doesn’t have to be this way, and it isn’t in much of the rest of the developed world. This level of unhappiness is not a worldwide condition, as you can see in Figure 2.

Part of the problem is that most people don’t actually know what will make them happy. As the Harvard Medical School



**Figure 1.** Percentage of persons ages 12 years and older who take antidepressant medication, by age and sex, United States: 2005-2008.

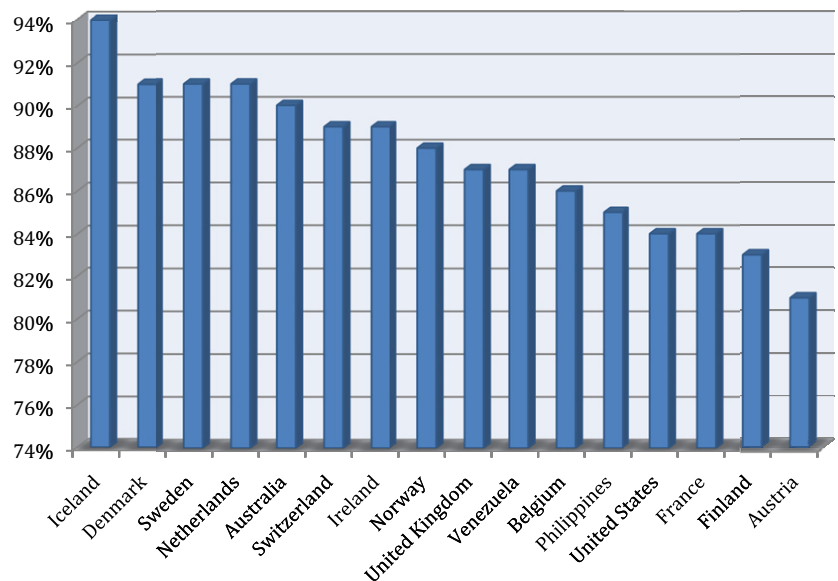
*Healthbeat* explained it, “People tend to be poor judges of what will make them happy. While most people say they want to be happy, they often believe in myths or carry assumptions that actually get in the way.”<sup>7</sup>

Three things which, it may surprise you, don’t produce happiness are money and material things (your mother was right); youth and physical attractiveness; and children.

The Harvard group explains, “The question of whether money can buy happiness has, for more than 30 years, been addressed by the ‘Easterlin paradox,’ a concept developed by economist Richard

Easterlin. His research showed that people in poor countries are happier when their basic necessities are covered. But any money beyond that doesn’t make much difference in happiness level.”<sup>7</sup>

The Harvard team do, however, list five things which do contribute to happiness: (1) when you do something you commit yourself fully, and “lose awareness of time;” (2) whatever you do give yourself over to it so that “you aren’t thinking of yourself;” (3) as you are doing whatever it is you do that makes you feel happy do it in a manner so you “aren’t interrupted by extraneous thoughts while you are doing it;” (4) be proactive in your life, not pas-



**Figure 2.** National Happiness Index. Definition: This statistic is compiled from responses to the survey question: “Taking all things together, would you say you are: very happy, quite happy, not very happy, or not at all happy?” The “Happiness (net)” statistic was obtained via the following formula: the percentage of people who rated themselves as either “quite happy” or “very happy” minus the percentage of people who rated themselves as either “not very happy” or “not at all happy.” Source: World Values Survey, 2005.

sive; and (5) although the work may be hard and demanding, you work at it effortlessly because you believe in what you are doing.<sup>7</sup>

If you can do that, you are “in the flow,” and that will lead to happiness.

And if you are happy, other people will be happy. As Rob Stein wrote in the *Washington Post*, “Happiness is contagious, spreading among friends, neighbors, siblings and spouses like the flu, according to a large study that for the first time shows how emotion can ripple through clusters of people who may not even know each other.”<sup>8</sup>

Stein is referring to research done by Harvard medical sociologist Nicholas A. Christakis et al., published in the *British Medical Journal*. Christakis says, “You would think that your emotional state would depend on your own choices and actions and experience.” It does not. Rather, as the paper concludes, “People’s happiness depends on the happiness of others with whom they are connected. This provides further justification for seeing happiness, like health, as a collective phenomenon.”<sup>9</sup> This conclusion is based on studying 4,739 individuals for two decades, from 1983 to 2003, and its conclusions go well beyond generalities.

As reported in the study, “Longitudinal statistical models suggest that clusters of happiness result from the spread of happiness and not just a tendency for people to associate with similar individuals. A friend who lives within a mile (about 1.6 km) and who becomes happy increases the probability that a person is happy by 25% (95% confidence interval 1% to 57%). Similar effects are seen in coresident spouses (8%, 0.2% to 16%), siblings who live within a mile (14%, 1% to 28%), and next-door neighbors (34%, 7% to 70%). Effects are not seen between coworkers.”<sup>9</sup>

Equally as important, the authors note, “The (happiness) effect decays with time and with geographical separation.”<sup>9</sup>

More recently, after further assessment of this data, Christakis and Fowler reported, “Happiness is a fundamental object of human existence. To the extent that it is synonymous with pleasure, it could even be said to be one of the ‘two sovereign masters’ that, Jeremy Bentham ar-

gued, govern our lives. The other master, lest we forget, is pain.

“Our happiness is determined by a complex set of voluntary and involuntary factors, ranging from our genes to our health to our wealth. Alas, one determinant of our own happiness that has not received the attention it deserves is the happiness of others. Yet we know that emotions can spread over short periods of time from person to person, in a process known as ‘emotional contagion.’ If someone smiles at you, it is instinctive to smile back. If your partner or roommate is depressed, it is common for you to become depressed.”<sup>10</sup>

This research and other studies suggest once again the interconnected and interdependent nature of a successful social order. It shows that happiness is not just a personal experience and goal. It is, instead, the property of a group, and emotions are both a personal and collective phenomenon.

Just as we know that drugs alone are not a solution, and are all too frequently abused, we know that a mix of meditation and psychotherapy can be extraordinarily effective. (See my article “Mediation—the controlled psychophysical self-regulation process that works.”<sup>11</sup>)

We have the tools to change our national consciousness for the better. The question is thus: are we really willing to make the commitment?

This trend, as with so many things in our culture gets down to a question of whether individual and national wellness are priorities. Other societies have populations that are significantly more happy than we in the United States. If we are not happy, we have no one to blame but ourselves. Perhaps a good place to start a quest for national wellness would be to tell ourselves the truth about ourselves.

## REFERENCES

1. Derrida J. *Dissemination*. Johnson B, trans. Chicago, IL: University of Chicago Press; 1981, p. 70.
2. Antidepressant Medications. *Psych Central*. (2006). Available at: <http://psychcentral.com/lib/2006/antidepressant-medications/>. Accessed April 13, 2012.
3. Pratt L, Brody D, Gu Q. Antidepressant use in persons aged 12 and over: United States,

2005-2008. CDC. Available at: <http://www.cdc.gov/nchs/data/databriefs/db76.htm>. Accessed April 15, 2012.

4. Olfson M, Marcus S. National Patterns in Antidepressant Medication Treatment. *Arch Gen Psychiatry*. 2009;66:848-856.
5. 1-in-4 women take medication for mental health condition, *RedOrbit*, November 17, 2011. Available at: <http://www.redorbit.com/news/health/1112425236/1-in-4-women-take-medication-for-mental-health-condition/>. Accessed 14 April 2012.
6. Antidepressant use up 75 percent. *Psych Central*. 2009. Available at: <http://psychcentral.com/news/2009/08/03/antidepressant-use-up-75-percent/7514.html>. Accessed 12 April 2012.
7. The happiness-health connection. *Harvard Medical School*. 2010. Available at: <http://www.health.harvard.edu/healthbeat/the-happiness-health-connection>. Accessed April 15, 2012.
8. Stein R. Happiness can spread among people like a contagion, study indicates. *Washington Post*. December 5, 2008. Available at: <http://www.washingtonpost.com/wp-dyn/content/story/2008/12/04/ST2008120403608.html>. Accessed April 15, 2012.
9. Fowler JH, Christakis NA. Dynamic spread of happiness in a large social network: longitudinal analysis over 20 years in the Framingham heart study. *BMJ*. 2008;337:a2338.
10. Christakis NA, Fowler JH. Happiness is a network property, not just a personal state. *Nexalogy*. 2012. Available at: <http://nexuslogyenvionics.com/physics-and-social-media/happiness-is-a-network-property-not-just-a-personal-state/>. Accessed April 14, 2012.
11. Schwartz SA. Mediation the controlled psychophysical self-regulation process that works. *Explore*. 2011;7:348-353.

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