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us into a long discussion of modern social science, relativism, positivism—is there such a thing as the good, who is to say, etc. I leave all that aside, but I point out to you that, unless what is in each is good, why should we want to bring it out? Do we not necessarily imply that what is there is good by the very fact that we want to bring it out? Could anyone seriously argue for leading forth the bad? By the very word education and by our actions we presuppose the Aristotelian or Thomistic—or one variation or another of them—ideas of the natural law impressed upon the human heart.

### Everests of the mind

To educate, therefore, is to educe, and that means to lead forth from the superior few the richness that is within them, and from the many to lead forth the lesser excellence that is in them. We must recognize and cultivate the superior student wherever he is to be found, of whatever race, class, of whatever ethnic or social origin. That is what democracy rightly demands of us. But we must not allow democracy to become a dogmatic egalitarianism that does not welcome eagerly the naturally superior, whom Jefferson's system sought out. That dogmatic egalitarianism is dangerously popular in an age of mass democracy. We have got openly and unabashedly to resist it. That means to teach students that thoughtful reading is a profoundly difficult job, that there are no reading shortcuts to grasping the great writers. We must teach the young that there are men who came before them who attained almost unimaginable heights, and whose works are like Everests of the mind, to be ascended by the gifted and determined few. At first there is something hateful in this to many of the young; it is disagreeable to be made to see that there were giants who preceded you, whom you must approach with care and respect. But the student can learn to love the fact that genius is the fruit of human inequality, that the past is as wise as the present, and that a great step toward becoming fully human is to lift yourself up by careful and thoughtful reading of truly demanding works. Those who teach reading in this age of mass democracy have the obligation and opportunity to instill that love of superior things.

## The medicalization of unhappiness

RONALD W. DWORKIN

**T**HE use of psychotropic medication in depressed patients has increased in the United States by more than 40 percent over the last decade, from 32 million office visits resulting in a drug prescription to over 45 million. This is in marked contrast to the period between 1978 and 1987, when the number of office visits resulting in a psychotropic drug prescription remained relatively stable. The bulk of the increase can be accounted for by the aggressive use of SSRIs (selective serotonin reuptake inhibitors) in patients. It is the class of drugs that includes Prozac, Zoloft, and Paxil. The question is: Are more Americans clinically depressed now than in the past, or has medical science started to treat the far more common experience of "everyday unhappiness" with medication, thereby increasing the number of drug prescriptions?

No one knows the answer to this question. We do know that the number of patients diagnosed with depression has doubled over the last 30 years, without any great change in

diagnostic criteria. But this simply raises another question: Are doctors more aggressive in diagnosing depression, or are they simply diagnosing "everyday unhappiness" as a variant of depression and reporting it as such?

These questions are at the center of a major debate within the medical community over who the new patients being treated with antidepressants are and what treatment guidelines are being used. There is suspicion among some doctors that it is not the sickest patients who are being given psychotropic drugs but those patients who complain the loudest about being unhappy. Some physicians blame managed care for the problem of over-prescription. Because the office environment under managed care is so rushed and impersonal, many doctors take the path of least resistance by prescribing medication whenever a patient is feeling "blue." Also, managed-care companies save money when depressed patients receive medication rather than an indefinite number of counseling sessions.

This suspicion is well founded, but the origin of the problem does not lie solely in managed care. The sources of over-prescription are much more complex. Physicians are being encouraged to think about everyday unhappiness in ways that make them more likely to treat it with psychotropic medication. It is part of a growing phenomenon in our society: the medicalization of unhappiness.

In the past, medical science cared for the mentally ill, while everyday unhappiness was left to religious, spiritual, or other cultural guides. Now, medical science is moving beyond its traditional border to help people who are bored, sad, or experiencing low self-esteem—in other words, people who are suffering from nothing more than life.

This trend first became widely known with the publication in 1992 of *Listening to Prozac*. Peter Kramer's book, which became a national best-seller, described the positive benefits enjoyed by depressed patients when they were put on Prozac. The drug apparently increased self-esteem and reduced negative feelings when nothing else could. The book led many in the medical community and the broader public to look more favorably on a liberal use of antidepressants.

Medical science should aggressively use drugs like Prozac for patients suffering from clinical depression. This is totally

appropriate—and important. But medical science errs when it supposes that a connection exists between everyday unhappiness and clinical depression, something it increasingly does. It is hard to know where everyday unhappiness ends and clinical depression begins, and there is no easy way to distinguish between borderline depression (i.e., low spirits without any physical signs or symptoms) and everyday unhappiness. Traditionally, doctors have relied on their wisdom, intuition, and personal experience to separate the two. Such a method is neither precise nor foolproof, but it is possibly the best we can aspire to. The problem is that medical science has placed everyday unhappiness and depression on a single continuum, thereby interfering with the efforts of doctors to make fine but necessary distinctions.

Medical science has adopted a method of classifying mental disorders that blurs the line between sickness and health. And more radically, it has embraced a theory that explains all mental states in terms of their biochemical origins. Medical science has done this in order to make the problem of unhappiness simpler and more comprehensible to doctors. But the new science actually works against the efforts of doctors to separate everyday unhappiness from depression. The upshot is that physicians are more likely to treat mere unhappiness the way they would treat serious mental illness—with psychotropic drugs.

### Categories of unhappiness

One way that science establishes a link between clinical depression and everyday unhappiness is through a diagnostic instrument called the DSM. First published in 1952 and now in its fifth edition, the DSM (*Diagnostic and Statistical Manual of Mental Disorders*) is the essential diagnostic tool in the psychiatric field. It is a classification scheme for the entire range of human mental pathology. The DSM includes 16 major diagnostic classes (e.g., mood disorders, anxiety disorders, substance-abuse disorders), and these categories are divided up again and again in accordance with certain signs and symptoms. The DSM was originally developed by psychiatrists and psychologists, but even primary-care physicians refer to its nomenclature and categories in determining whether or not a

patient has a significant mental illness.

The original purpose of the DSM was to satisfy the psychiatric profession's need for statistical and epidemiological data. But by establishing a relationship between clinical depression and everyday unhappiness when no such relationship existed before, the DSM has led inexorably to a liberal use of psychotropic medication.

Prior to the development of the DSM, feelings of unhappiness were not considered related to any of the authentic disease states that existed in medical science, such as depression or schizophrenia. While clinical depression had an official status in medical science, everyday sadness did not. The DSM changed this by creating large categories of mental illness and then ever-increasing subcategories, replete with subtypes and specifiers. "Major depression," for example, was broken down into a host of subtypes, including "minor depression," which was broken down further into symptoms of everyday unhappiness like pessimism, hopelessness, and despair. With the creation of the DSM, everyday unhappiness suddenly gained a fixed position in medical science, if only as a subcategory of a subcategory of a major mental illness.

The DSM incorporates everyday unhappiness into medicine in another way. It encourages doctors to use its multiaxial system, which allows the mental state of a patient to be assessed in different ways. For example, Axis I is used for reporting any major mental disorders. Axis III is used for reporting a patient's general medical condition. Axis IV is used for assessing a person's psychosocial and environmental problems. It is within Axis IV that everyday unhappiness takes a position within medical science. For example, one can find on Axis IV job dissatisfaction, discord with one's boss, or trouble with one's spouse. Such everyday troubles are given their own special diagnostic code in a companion book called the *ICD-9 (International Classification of Diseases)*. Trouble with one's spouse, for example, is listed as Partner Relational Problem, and is assigned number V61.1. Through the use of this multiaxial system, everyday unhappiness is brought into the orbit of medical science.

By itself, this does not lead to an increased reliance on psychotropic medication. The problem arises because the cat-

egories of mental illness in the DSM are so porous as to allow everyday unhappiness to pass into the category of a more significant disease. The diagnosis of "minor depression," for example, requires only a feeling of sadness and a loss of pleasure in daily activities—a mood that may characterize the pain of everyday life as well as any medical pathology. Because "minor depression" often gets treated with medication, so too does everyday unhappiness.

"Adjustment disorder with depressed mood" is another DSM category that has the potential to be confused with everyday emotional trouble. Included in this diagnostic group would be the person who is sad and tearful because of some painful event, like the termination of a romantic relationship or a sudden business difficulty. Distinguishing an adjustment disorder from the despondency that people might feel during one of life's routine downturns can be very difficult. Because adjustment disorders are often treated with medication, everyday unhappiness is too.

Another catch-all category is "Depressive Disorder NOS (Not Otherwise Specified)." An example of a patient with "Depressive Disorder NOS" was described to me by a psychiatrist as someone who says, "Doctor, I'm feeling sad and my sleep is restless. I don't know if I'm depressed or getting depressed, but I'm feeling down. My appetite is fine and I've got plenty of energy, but I'm unhappy." Such a patient may be a candidate for antidepressants.

Doctors have long recognized this deficiency of the DSM, but it was not a serious problem in 1952 when it was created. Psychotropic medications were not as readily available as they are now, so doctors could not use drugs to treat everyday unhappiness even if they had wanted to. With the development of psychotropic medications, doctors now can. The combination of safe, effective drugs like Prozac and a relatively imprecise method of categorizing mental pathology results in a wide use of psychotropic medication in borderline cases of depression.

Many psychiatrists argue that over-prescription is largely the fault of primary-care physicians, who provide the majority of mental-health care in this country. In the view of the psychiatrists, primary-care physicians are not sufficiently well

versed in the nuances of the DSM to use it properly. In one study, over 30 percent of the family practitioners interviewed confessed to needing further training to treat emotional disorders, even though it was part of their routine practice to do so. But even though mental-health professionals are more experienced in treating depression, patients do not want to be referred to a psychiatrist or therapist for fear of the stigma attached—the fear of being thought “crazy.” For this reason, they insist on being treated in the primary-care setting, where expertise in managing mental illness is not great. Again, the result is an increased use of psychotropic medication in cases of everyday emotional trouble.

### The “laws” of sadness

While the potential for diagnostic error may cause some doctors to think twice about aggressively writing drug prescriptions, a new medical theory actually justifies the liberal use of psychotropic drugs. Doctors now point to a biochemical mechanism that comes close to uniting serious mental pathology and everyday emotional trouble under a single principle. It is called the “biogenic amine theory.”

According to this theory, blocking the reuptake of serotonin or other neurotransmitters in the brain has a positive effect on the human psyche. Chemical compounds like serotonin, dopamine, noradrenalin, and acetylcholine are the means of communication across nerves. Since many of the drugs used to treat depression increase the amount of these neurotransmitters available in nerve spaces (called synapses), it is reasoned that depression might be caused by a deficiency of amines at the level of the nerve junction.

The biogenic amine theory has been in existence for several decades. It was developed through a series of inferences after the first generation of antidepressants, called tricyclics, was created. Because these drugs brought about an improvement in mood, and because they had a specific effect on the amines in nerve terminals, researchers concluded that amines must regulate mood.

While Kramer's *Listening to Prozac* examined the effects of Prozac on patients who were clinically ill, new research focuses on the effects of Prozac and other SSRIs on everyday

unhappiness. According to medical science, the normal spectrum of individual differences in mood and social behavior may be tied to the same mechanism of neurotransmission that governs real mental pathology. One study postulates that different components of the human personality may have their own neurochemical substrates. These unique substrates, such as dopamine and serotonin—the same substrates involved in the biochemistry of clinical depression—may modulate the expression of everyday happiness and sadness.

Physicians have this theory in the back of their minds when they see depressed patients. They admit that depression may have many causes, but they still insist that moods are ultimately determined at the neuronal junctions of the brain where antidepressants work. In their view, all unhappiness necessarily leads back to these junctions in the same way that all roads once led to Rome.

This mindset prepares the way for a broad use of antidepressants. Because the DSM is a relatively arbitrary classification scheme, physicians think that even though their depressed patients may not fit the necessary diagnostic criteria for depression, they “almost do.” And because the criteria for depression change with virtually every new edition of the DSM, being slightly off should not prevent a patient from receiving drug treatment, especially since his unhappiness, whatever its cause or level of intensity, will find its way back to the neuronal junctions of the brain as readily as all forms of depression.

Patients think in a similar vein. They understand that the classification scheme by which physicians measure the intensity of depression is arbitrary, and that the difference between a DSM-sanctioned depression and a more mild depression is not at all like the difference between being pregnant and not being pregnant. One cannot be a “little pregnant,” but one can be a little depressed. In the minds of patients, the various shades of depression merge into a single unity that expresses itself eventually at the brain's neuronal junctions.

The proven value of psychoactive drugs in treating a wide spectrum of depressed patients encourages people who are just unhappy to ask for them. It seems unfair that patients who fit the DSM criteria for depression get to enjoy the quick benefits of drug treatment while those who do not are forced

to endure the long, often painful process of talk therapy—a process that seems obscure and confusing and, to some, a bit dubious. Thus symptoms of depression are increasingly treated according to their level of intensity rather than according to their specific cause, which is unknown anyhow.

### Is this happiness?

The neuronal junctions of the brain where psychotropic drugs exert their effect are looked upon by medical science as a kind of corridor between matter and mood. Here at the subcellular level, the mystery of the human mood is believed to play itself out. A quantum of neurotransmitters is released at the neuronal junctions and a person's mood either rises or falls. The feeling of happiness gains an absolute unit of measurement in medical science and becomes, for all practical purposes, a visible phenomenon.

The flaw in this theory can be understood in the following way: Matter and mood are two different phenomena, as different as light and air, and so can have no physical interface. Just as light and air cannot affect one another, since there is no place in the universe where they "meet," neither can matter and mood affect one another, since there is no place in the physical world where they meet. One is finite, the other is infinite; the two are composed of different substances and so can never be joined together in physical reality.

It is true that neuronal junctions exist in the brain and that complex changes occur within these junctions during mental activity. But this does not necessarily make them a place where matter and mood share a common boundary. To say that they do is like watching a person get into a car, then seconds later watching the car move, and from this observation making the deduction that the car moves because someone gets into it. It is a false science to infer from the study of matter a knowledge any deeper than that of knowing the forms of matter and their relationships. It is a false science to say that on the basis of material knowledge, one can pretend to "know" and understand the emotional experience of life.

Kramer suggests that feelings like homesickness or loneliness are mediated through neurotransmitters like serotonin, or possibly encoded in neurons, and the fact that Prozac eases

these conditions seems to confirm this view. But the notion that matter and mood can have a direct connection with one another—that somewhere at the neuronal junction, loneliness and serotonin "meet"—is tantamount to saying that the human mood is material, and that it can be touched by matter. Buried within the biogenic amine theory is an illogical belief—that neurotransmitters are shedding their physical existence, becoming even smaller than atoms, and ultimately merging with pure thought or idea.

The error in the biogenic amine theory can be understood in a slightly different way. Augustine once said that the human heart has more moods and emotions than hairs on the head or stars in the sky. What he meant by this is that happiness has an infinite number of shades, reflecting the infinite that is the human soul, which mirrors the infinite that is God. Even if every particle of serotonin crossing the synaptic cleft of a nerve terminal could be measured, along with every particle of noradrenalin and dopamine, the number of particles would still be finite, while the moods of a human being would still be infinite. By definition, there are simply not enough particles to express every conceivable human mood.

### Creating virtual realities

But what about drugs like alcohol or narcotics? They alter our moods when ingested, producing feelings like euphoria and indifference. Is this not a case of matter affecting mood by way of a common border inside the brain?

No, it is not, and this is key to understanding how drugs like antidepressants really work. Alcohol and narcotics do not produce such feelings by being received directly into the "substance" of human emotions. On the contrary, they simply alter human consciousness in a way that allows the mind to shift its mood. These drugs work by dampening certain aspects of brain function—they create an *altered mental state*—such that true reality becomes concealed from a person's consciousness. The dampened brain functions allow a person to imagine an alternate "reality" that is generally more pleasing.

For example, when a man contrasts his humble circumstances with some ideal of success, tension arises in his psyche. His conscience berates him, and he feels the well-known mis-

ery of failure. He might try some diversion, like golf or stamp-collecting, in order to hide from himself what he does not want to face, but sometimes the diversion does not sufficiently block the sight of things that he dislikes. So he starts to drink, and the alcohol alters his consciousness in such a way that he is diverted. After ingesting alcohol, the eye of his mind no longer sees the images that were causing him so much pain. At this point, the man starts to feel better, even "happier."

Drinking is a reliable method of dealing with unhappiness not because it exerts a direct effect on a person's mood but because it helps conceal from view what he does not want to see. It is by dampening or altering brain functions and by affecting consciousness that alcohol transforms how we feel.

It is the same with antidepressants. They are merely another form of stupefaction. True, people who take them because they are unhappy are not like alcoholics or drug addicts—they function at work, they are well mannered, and they do not vomit in the streets. But although their method is "cleaner," they are attempting the same thing as the person who uses alcohol to raise his spirits. Unlike the drunk, their minds remain awake, clear, and lucid, but the drugs have still tampered with their brain functions, hiding from them what they do not want to see.

This point was revealed to me in the case of one friend who was taking Prozac for general unhappiness, though not under my supervision. He said, "I feel a lot better. I don't have to look into the abyss anymore. I see my problems, but they don't seem as daunting as they once did." With the help of a psychoactive drug, he was able to retire further and further from his mind's sight those images that were painful to him. He still saw their visible outlines, but his new mood was based on an altered perception of their image. He was no longer menaced by them because they had grown distant to him.

The same phenomenon can account for what Kramer calls "cosmetic psychopharmacology." Kramer reports with amazement how one of his female patients, after taking Prozac, changed from a social misfit into an accomplished coquette, capable of maneuvering smoothly from one man to the next, even of securing three dates in a single weekend. But is this

any different from what alcohol might do for someone with similar hesitations? Is this really a "new self" courtesy of Prozac? Of course not. A woman wants to flirt with men, but her self-doubt tells her not to do so. The result is tension and unhappiness. So she takes alcohol in order to silence the critic within and feel "liberated." This is nothing new.

### Prozac nation

Yet despite the rather obvious nature of antidepressants, medical science studiously avoids putting antidepressants in the same category as alcohol and narcotics. It struggles to preserve the deceit of a special mood-matter link at the level of the neuronal junctions. Why is this so? Why does it bother to support the irrational notion that mood and matter share a common interface? To the degree that it is a conspiracy, it is one enjoined by our entire culture: People desperately want to believe in such a link; they want to believe that the cause of happiness is located in the physical world, and that happiness somehow comes about scientifically in the form of a pill. The promise of such a view is security and comfort.

First, to admit one's dependence on psychoactive drugs is to shield oneself from life's imponderables and unpredictability. If happiness is serotonin, and serotonin is happiness, then these drugs guarantee happiness, for one can take psychoactive drugs for years. It is with this attitude that people with mild depression might substitute the chance of real happiness with some semblance of happiness achieved through medication.

Second, to declare happiness a law of necessity allows science to emphasize the subcellular processes inside the brain at the expense of everything else. Science can say: "It is man's basic nature to want happiness, but if the natural desire for happiness is linked to the physical nature of his brain, it cannot be linked to culture, which varies from society to society. The search for happiness begins and ends in nature, and so there is no reason to go beyond science." By believing this to be true, people can put aside other approaches to coping with daily troubles—which is convenient, since these remedies, whether they involve talking to a friend or asking for divine guidance, are never a sure thing.

Third, the notion that happiness is a law of science appeals to human pride. If unhappiness is chemical or biological, along with its treatment, a person need not ask, "Why am I unhappy?" In the past, this question provoked serious introspection and self-examination, as the effort to cope with unhappiness merged with larger questions about life and existence. Religion and philosophy demanded that people see themselves as part of a larger whole and taught that happiness depended on more than self-satisfaction. But if happiness is a law of science, then one does not have to go through this humbling experience. Through drugs, one can find happiness as a single, isolated individual.

Fourth, and perhaps most crucial, depressed persons equate the pleasant mood evoked by psychoactive drugs with happiness, even though, in the depths of their hearts, they are not sure exactly what they feel. Still, people do not want to live a lie, and so they will accept their drug-induced "happiness" as the real thing only if they believe that science has truly uncovered the biology of happiness. And this is what the biogenic amine theory of matter and mood represents. It reassures people who take medication that their good feeling is indeed happiness.

For people suffering from clinical depression, the mental state produced by these drugs must be considered an improvement, and often, a necessary one. But for those people who suffer from unhappiness, perhaps because of stress or because they are in bad relationships, these drugs are nothing more than a shortcut to a particular mental state that they believe to be happiness but is not.

### Your mind on drugs

What exactly do people feel when they take antidepressants? It is difficult to say because each person expresses the feelings aroused by medications like Prozac differently. There is simply no universal feeling. Nevertheless, a broad understanding of the phenomenon is possible, and what emerges among medicated patients is a definite change in consciousness.

In most of the testimonies published, patients note that the good feeling arising from the influence of mood-modifying

drugs does not come about immediately. It often takes several weeks, and this delayed effect is considered to be so predictable that doctors warn their patients about it. The slow onset of the drug causes the change in people's attitude to be barely perceptible. There is generally no minute or hour that marks the onset of their improved mood.

And so it is not surprising that after people start taking medication, life continues by virtue of its own momentum. If, before taking the drug, people biked for recreation or shopped because it was their favorite pastime, they generally do so afterward. Except in rare cases of "cosmetic psychopharmacology," described by Kramer, the tastes and interests of a person do not change; the person on medication remains the same person.

For this reason, however, it cannot be a change in life that causes the uplift in spirit, since for the people taking these drugs, life does not change. Generally, most people calculate their happiness by external circumstances. But psychotropic drugs enable people to feel better even though their external circumstances are unchanged. The cause and effect relationship that has dominated their lives is not working properly, and while they feel better, they are confused.

Patients on psychotropic drugs still react to specific external events in an appropriate manner. Their mood goes up or down according to what happens in their environment. But while these patients may smile at a party or laugh at another's jokes, I have often observed a general lack of congruence between outside circumstances and a medicated patient's good feeling, and this observation is commensurate with the amazement expressed by these people at feeling well despite the lack of change in their outside circumstances. The outside world becomes, in a way, detached from their inner life. Its influence decreases.

Casual conversation with hundreds of patients taking psychotropic medication serves as the basis for this opinion. One patient of mine who was asked on a pre-operative evaluation how medication helped him replied, "I see the same things as before, but I don't care so much. I still feel good no matter what happens." Another patient in the same situation said, "I don't know why. I just feel really good about myself." For such people, the relationship between their outer life and



their inner life becomes like two wheels that once rotated in tandem, and continue to do so, but are now ever so slightly off, with barely different speeds, such that while they appear to be connected by an axle, it is impossible for them to be so.

People medicated for depression often talk about enjoying activities that they did not enjoy prior to starting medication. But again, there is something suspicious in their pleasure. For example, two friends of mine told me that they "felt better" on medication, which enabled them to play tennis and feel good again while doing so. Yet it was not so much that they extracted pleasure from playing tennis but, rather, brought the pleasure they enjoyed through medication into this activity. It was a pleasure that they experienced for no discernible reason, and it mildly confused them since, deep down, they were the type of people who felt good only when external circumstances were going their way. Yet nothing in their lives had changed but a pill.

It has been observed that people who are not depressed and who take psychoactive drugs sometimes feel uncomfortable. The above observation might explain this phenomenon. The mood of such people is altered by drugs, but in a way that they cannot understand. They become like the traveler in a boat who feels confused by the imperceptible changes beneath his feet, and worse, has no beacon on the horizon on which to fix his gaze. He cannot establish a connection between what he is feeling and what he is seeing, so he starts to feel queasy. Nothing in the outer world seems to move, and so he cannot ascribe his inner feeling to an outside event. And if he does find a beacon sitting on the horizon, he cannot readily admit to himself, "Yes, I feel this way because of what I see," since what he sees never produced a feeling like this before. The whole thing makes no sense, and so he starts to feel seasick.

### Know thy self

Psychoactive medication, much like alcohol and narcotics, causes a disconnect between the inner and outer life. This is the problem with using it to treat everyday unhappiness. The disconnect caused by medication is very different from the state of thoughtful detachment encouraged by many cultures for the purpose of insulating people from everyday disappoint-

ment. The latter contributes to wisdom, stability, and maturity; the former creates a state of mind that is stuporous and purposely unknowing.

Medical science should confine itself to the treatment of clinical depression, rather than extend itself into the realm of everyday unhappiness. Medical science "helps" unhappy people by clouding their thoughts, by making them less aware of the world, and by sapping their urge to see themselves in a true light. People medicated for everyday unhappiness gain inner peace, but they do so through a real decrement in consciousness.