Revus
Journal for Constitutional Theory and Philosophy of Law / Revija za ustavno teorijo in filozofijo prava

10 | 2009
Človekovo dostojanstvo in duševno zdravje

One Health Only

Eno samo zdravje

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Electronic version
URL: http://journals.openedition.org/revus/1060
DOI: 10.4000/revus.1060
ISSN: 1855-7112

Publisher
Klub Revus

Printed version
Date of publication: 1 September 2009
Number of pages: 89-93
ISSN: 1581-7652

Electronic reference
Andrej Marušič, « One Health Only », *Revus* [Online], 10 | 2009, Online since 22 January 2012, connection on 21 April 2019. URL : http://journals.openedition.org/revus/1060 ; DOI : 10.4000/revus.1060

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One Health Only[1]

Prispevek poudarja celostno naravo zdravja kot ene same celote telesnega in duševnega stanja oziroma delovanja pri posamezniku. Če naše telesno počutje ni optimalno ali celo resno zbolimo, se bo to neizogibno poznalo tudi na področju duševnega zdravja. Povezave pa gredo v obe smeri, saj so tudi duševne motnje povezane z raznovrstnimi telesnimi simptomi. Žal se tesna prepletenost obeh dimenzij zdravja v raziskovalnih in kliničnih krogih do danes še vedno pogosto zanemarja ali podcenjuje. Da bi zmogli obolelemu posamezniku kar se da učinkovito pomagati, pa je nujno, da si strokovnjaki, ki ga obravnavajo, na njegovo zdravstveno težavo prizadevajo pogledati širše, tudi izven okvira svoje ožje specialnosti. Kadar se torej lotevamo področja zdravja, bodisi klinično, raziskovalno ali pa v smislu načrtovanja javnozdravstvene mreže in storitev, kaže slediti načeloma večdimenzionalnosti in interdisciplinarnosti. Samo tako bodo naša prizadevanja poplačana s kar najvišjo možno učinkovitostjo oziroma kar z najboljšim končnim izidom.

Ključne besede: duševno zdravje, telesno zdravje, sopojavnost motenj telesnega in duševnega delovanja, celosten pristop k zdravju

It is high time to recognise that there is one health only and start working towards providers of a comprehensive type of health care. These should not, rely only on a somatic and psychiatric approach in case of comorbidity. There are social networks and interpersonal relationships to consider as well. Health care and prevention of non-health should not be divided. A dichotomous division into the health of a body and soul is of little help to a person who would just like to get out of distress or get better or to get rid of his chronic pain or disease. For him or her, ways to their only health have accordingly only one end or aim and that is “Get healthy!” As we say in Slovenia, while a healthy person has thousands of different wishes, the unhealthy one will only have one.

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[1] Besedilo je še neobjavljen avtorski članek prof. dr. Andreja Marušiča. Ker je članek v originalu napisan v angleškem jeziku, ga tako tudi objavljamo.

1 MENTAL HEALTH AS A PART OF ONE HEALTH ONLY

Although the overall impact of mental health problems was largely underestimated in the past, mental ill health is getting recognised as a leading cause of disability[2]. In Europe depression is present in approximately every twentieth person every year. Mental ill health, particularly depression can even lead to suicide. This is, however, not the whole summary of the story. The mental ill health is also related to the somatic ill health. For example, back pain can be the consequence of mental health problems and, reversely, people suffering from a painful long-term chronic disease are more often affected by major depression than the general population. Furthermore, the mental ill health has serious repercussions on our wellbeing and on social, economic and educational aspects of our lives. In other words, evidence suggests an important role for the mental health in general health[3]. Even if the mental health is considered as a speciality on its own, it is the least specialized as it gets inter-related with health in a generalized way. Could the mental health, at least partly, account for changes in the somatic health in an individual who is getting better from his/her somatic illness? Or the other way around, could the somatic health account for changes in somebody's mental health status? For example, the mental and somatic health are reciprocally connected in such a way, that changes in one automatically cause changes in the other. If so, perhaps it would be better to see it as one health only.

The aim of this article is to discuss the mental health as a part of one health only. Firstly, I will speculate that one person's ill health might be seen as different types of ill health because of a different expertise of the expert. Secondly, a possibility for measuring a degree of overall ill health will be suggested. Accordingly, the re-evaluation of some projects aiming at mental health improvements will be suggested; their effect on the somatic health and health in general may not have been taken into account. Finally, the movement from the mental health as one of the health determinants to the mental health as the main health indicator of the interplay between unpleasant life circumstances or events on one side and the quality of health care on the other will be suggested.

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[2] World Health Organisation, *The world health report 2004 – Changing History*, Ženeva, Svetovna zdravstvena organizacija, *http://www.who.int/mental_health/media/en/244.pdf* (2. avgust 2009).

[3] Geoffrey G. Lloyd, Liaison psychiatry, v: Robin Murray, Peter Hill, Peter McGuffin (ur.), *The essentials of postgraduate psychiatry* (3. izdaja), Cambridge University Press, 1997.

2 A 47-YEAR-OLD

When we have to deal with a person in distress (perhaps with a disorder or with an illness already), lets say with a 47-year-old married (with relationship problems) father (with worries about his children), employed (but at risk of being unemployed), with a backache, without any motivation for everyday tasks, with some deep pain around his heart, with no libido, who sleeps when he sleeps, but does not really wake up rested as he used to, ... we might be asked to diagnose him. He has just recently stopped his regular physical activity but he has “improved” in terms of his drinking behaviour.

The diagnosis will of course not depend on his “clinical” picture but rather on the expert-at-hand’s background: is she or he a medical doctor, specialized or not in some medical branch; is he or she a psychologist, sociologist, perhaps even an accountant? A psychiatrist will come to the conclusion that we are dealing with a mixed depressive-anxiety disorder, a psychologist will describe a neurotically characterised personality with interpersonal relationship problems and a sociologist will very likely elicit poor social network whereas a primary care family doctor will think of something along the line with a burnout syndrome. An orthopaedic surgeon will start to understand his lumbar pain. An accountant will notice that his papers are not in order and more taxes will have to be paid than the year before. A therapy will vary accordingly.

Without unnecessary exaggeration, his relative lack of optimal health will most likely be observed by relying on different methods and as such reported as different outcomes of poor health. These various reports are however representing one and only person and a gap between his current status and his perceived optimal health, the gap he is suffering from. What we usually do not appreciate is the interplay of the somatic and mental health on one side and the perception of poor health on the other[4]. Indeed, the gap between the currently unsteady state of our 47-year-old gentleman and his optimal health is probably described in different ways because of the underestimation of this interplay.

3 UNDERESTIMATION OF INTERPLAY BETWEEN SOMATIC AND MENTAL HEALTH

Lets imagine that we are not dealing with one of many cases in our epidemiological studies. If this was an epidemiological-method-free day, depressive disorders would be noticed more often in patients with a somatic illness than in those without it; a relation that has been outlined on many occasions so far

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[4] Mark Olfson, Steven Shea, Milton Fuentes, Yoko Nomura, Marc Gameroff, Myrna M. Weissman, Prevalence of anxiety, depression, and substance use disorders in urban general medical practice, *Archives of Family Medicine*, 2000, 9, 876–883.

in brain infarction, cancer, Parkinson disease, myocardial infarction, diabetes, rheumatoid arthritis. etc. Moreover, up to one third of medical inpatients report mild to moderate symptoms of depression but do we notice them while not studying them specifically for their depressive state? Up to one quarter of patients attending their primary care or family doctor have a mental disorder and these tend to present with somatic symptoms only[5].

They can only be seen as people with a somatic disorder; perhaps as people with comorbid depression in almost ideal world. In the best scenario, a liaison team will be formed to manage all comorbidity cases. However, their health will still be perceived as lacking in two different ways but not as a globally impoverished one and as such requiring a comprehensive way of putting it back together. The patients with somatic illness and depression have poorer levels of functioning and higher levels of mortality and morbidity compared to the patients with similar illnesses but without depression[6].

Of course, health can be absent in a very isolated way. If this is extreme, a specialized care will be needed as soon as possible. In such cases a specialized background of the expert is of great help. However, health is more often lost in many ways or at least seen as lost from various perspectives requiring a comprehensive approach and not a specialized one. In distress one will only perceive a relative, short-term disequilibrium of health that remains inside the given quality of health. A disorder or an illness will on the other hand represent a qualitative change of the health status. Both quantitative and qualitative changes in general health are indeed measurable but they should not be measured by one approach only.

4 MEASURING A DEGREE OF OVERALL ILL HEALTH

Lets go back to our 47-year-old father. We could invite all outlined experts and asked them to provide their measurements of his ill health according to the standards of their speciality, e.g. a degree of back pain or to discuss hernia severity, a score on one of the scales measuring depression, a degree of emotional liability as part of his personality structure and a degree of poverty of his social network. The inter-relation of these measures should be taken into account during and after different therapies. Each effective therapy will most likely have an effect on all aspects of health. Furthermore, would it be too daring to suppose that a comprehensive approach is the most influential one with a significant impact on all measures of health?

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[5] Bedirhan T. Üstün, Norman Sartorius, *Mental illness in general health care*, Chichester, John Wiley, 1995.

[6] Wayne J. Katon, Lawson R. Wulsin, David Spiegel, The relationship between depression and medical illness, *Patient Care* (1999) 39, 12.

The re-evaluation of some projects aiming at mental health improvements will indeed be needed; their effect on the somatic health and health in general may not have been taken into account in the first place. For example, lets imagine a group of European researchers performing a mental health related project measuring changes in some mental health indicators after improving health services and introducing mental health promotion. There is a chance that some of the effects on the overall health were not noticed as they were not measured in the first place due to the underestimation of the interplay between the somatic and mental health and the perception of poor health. Or the other way around: the effect on the mental health as obtained by the somatically oriented projects has not been measured yet. The re-evaluation would be needed not only to support a past financial decision but also to add to our knowledge the non-existence of a border between the somatic and mental health.

Furthermore, it might be a good time for public health experts to move from the mental health as one of the health determinants to the mental health as the main health indicator of the interplay between the unpleasant life circumstances or events on one side and the quality of health care on the other. Life events and circumstances are known to have a considerable effect on our health in general with the mental health being the most acutely responsive and as such the most sensitive one. As such, the mental health should be developed into a most sensitive health indicator indicating some possible effects of a different quality of health care on one hand or life events and changed life circumstances on the other.